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Ministry of
Community and
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Policy
Development

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Three decades of change

The evolution of residential care and community alternatives in children's services

PREFACE

The purpose of this paper is to provide staff of the Ministry of Community and Social Services and servicer providers funded by the Ministry with a perspective on trends in children's services in Ontario from 1950 to 1980. In addition to providing background on the development of the different children's services, the paper presents data and information that should be useful to staff engaged in policy development, service planning and program development.

Both the chapter on developments in children's mental health and the chapter reviewing the research literature on the effectiveness of treatment programs were prepared by Dr. Gillian Doherty of Doherty Social Planning Consultants. The other chapters were contributed by Ministry staff.

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1. THE APPROACH TAKEN IN THIS PAPER

For a number of years, there has been much discussion and concern about the effects of "institutions" on children receiving service and the desirability of developing "community alternatives" to serve both children and their families. To provide a new perspective and the basis for further deliberations on these issues, this paper develops an historical overview of past and current service trends. The following sections discuss:

- the multiple service system approach taken in the paper
- broad social and service trends during the years from 1950 to 1980 that are reflected in the developments within the different children's services streams
- problems with the data.

A Multiple Service System Perspective

While much of the past public discussion has focussed on reducing reliance on training schools for juvenile delinquents and on the phasing down of large institutions for developmentally handicapped people, this review will use a multiple service system perspective, for several reasons. It has been commonly accepted wisdom for some time that there is considerable overlap between the various service streams now within the jurisdiction of the Ministry of Community and Social Services. For many children it is a matter of chance whether they receive service from the child welfare or the corrections or the mental health stream. It has also been noted over the years that some children's aid societies have in care a high proportion of developmentally handicapped children. Thus, a narrow focus on any one stream produces an incomplete picture of events, and may lead to ill-founded conclusions. Moreover, if the phasing down within one stream resulted in expansion or increased demand in another, this would be a very relevant and useful piece of information for future service planning. Consequently, an approach relating developments within the child welfare, juvenile corrections, children's mental health and mental retardation service streams is seen as providing the most complete and helpful overview.

There are several problems in trying to develop such an analysis. One is definitional. For most people, the word "institution" conjures up an image of a large plant, providing care to many residents, usually in a segregated fashion in an isolated or remote area of the province, but the reality is that Ontario has relatively few such institutions. Once the outstanding examples of "institutions" have been identified, drawing further boundaries becomes increasingly problematic. In addition, some facilities that at one time might have been considered "institutions" have, over the years, changed their physical plant and programs and become much more a part of their community, and thus could hardly be viewed as "institutions". To identify and trace the history of such individual facilities would, however, result in a very complicated and lengthy document.

This historical overview therefore will not be restricted to a clearly defined type of institution, but instead will encompass the various facilities that are now broadly defined as "children's residences" in the Children's Residential Services Act. The Act, which sets common standards for residential services within all four service streams, defines a "children's residence" as a building in which three or more children not of common parentage reside away from the homes of their parents primarily to receive residential care. While this definition includes many foster homes, the Ministry makes a distinction between group homes and foster care. As explained in the consultation paper proposing standards and guidelines for agencies placing children in foster care, foster homes that serve four or fewer unrelated children and operate on a parent model are considered separately from group homes (Foster Care, p. 13). That distinction will be followed here, and so foster care will be considered only in passing.

It must be acknowledged that a difficulty in using the broad classification of residential service chosen for this paper is that it includes what are commonly considered to be "community alternatives" or "community-based treatment or residential facilities". However, the broad definition of residential care will allow a tracing of broad trends in residential care and an identification of the inter-relationships among trends within the service streams without in any way trying to prescribe or develop the concept of "community alternatives". The paper recognizes, though, that considerable efforts are being made within all four streams to develop in-home and community-based services. This is particularly true of the last few years, which are outside the scope of this paper.

For the purposes of this paper, non-residential services are services provided to a child who continues to live at home or returns home after receiving residential service. These services that seek to keep a child at home, and may be called family support, in-home care or outpatient services, can be readily distinguished from those broadly defined as residential in this paper.

If knowledge and understanding of past and current service trends are to be useful in informing future decisions, it is essential that the results of recent empirical research about the effectiveness of both residential and non-residential programs be considered. Much of the reported research during the 1970s regarding the effectiveness of many of these approaches concluded that "nothing works." This paper includes a chapter reviewing the latest evidence that exists about both residential and non-residential programs in the children's mental health and juvenile corrections fields. The review covers published research reports selected on the basis of research design, outcome measures and information on factors that contributed to the success reported. Sufficient detail is included to enable readers with research or program interests to decide whether to follow up the original reports.

Broad Social and Service Trends

As background to the chapters that follow and the more detailed discussion of trends within particular service streams between 1950 to 1980, a number of general trends should be kept in mind.

Because of the post-World War II baby boom and immigration, the child population in Ontario grew dramatically between 1950 and 1960, grew less rapidly between 1960 and 1970, and declined between 1970 and 1980, as shown in Table 1. It is estimated, for example, that the population aged less than 18 grew by nearly 62% between 1950 and 1960, and by 19.5% between 1960 and 1970, but dropped by 8.4% between 1970 and 1980. Also, 13 to 17-year-olds constituted 32.4% of the population under 18 in 1980, compared with 23.2% of this age group in 1950.

Table 1

The Child Population in Ontario

Year	0-15(1)	0-17(2)	0-18	0-19
1950	1,236,000	1,362,000	1,426,900	1,493,100
1960	2,037,000	2,205,300	2,284,000	2,361,900
1970	2,357,900	2,635,000	2,772,500	2,980,000
1980	2,080,900	2,414,300	2,577,600	2,744,000

1. Children under 16 constitute the primary age group served by children's aid societies' mandatory protection services and by juvenile corrections. Children served by these systems may continue as wards past the age of 16.

2. Persons in the age group up to 18 are defined as minors under the Age of Majority and Accountability Act. Some children's services, however, may serve youths up to the ages of 19 or 21.

Source: Statistics Canada Catalogue No. 91-518 and supplement: intercensal estimates of the population as of June 1 of the given year.

In children's services, the years from 1950 to 1980 were a period of reform of service delivery as well as organizational consolidation. Programming offered in all of the children's services sectors discussed in the paper reflected an increased understanding of and emphasis on children's emotional and developmental needs, and greater specialization to meet the needs of the individual child. This was a time of growing professionalization of service providers, of more extensive training at the university and post-graduate levels and of the development of child care work as a field of specialization. Standards of recruitment were raised. Service planning was undertaken and decisions were made within a more professional context.

Growing affluence made possible increased spending on services. However, private contributions were not adequate to meet increased demands for services and rising costs. As a result, government became almost entirely responsible for both capital and operating costs of services that had formerly been supported by private funding.

Problems with the Data

It should be noted that it has been difficult to develop consistent historical statistics within service streams or comparable overall statistics. Within service streams, for example, some statistics on children served may deal with numbers served at one point in time and others with numbers served over a period of time. Data gathered for some years, for example on facility capacities, may cease to be collected in later years. While aggregate statistics are generally available over the years, any refinements or sub-categories, such as populations by specific age groups or facilities, may be available only through extrapolations. Also lacking are accurate historical counts of shifts of children between systems. One child may be counted more than once in a given year because of repeated incidents of service within one service stream or in several streams. Consequently, any comparative data across streams, particularly total numbers of children served by all streams, must be approached with caution, and should be viewed as providing only very broad trend indications.

2. THE SHIFTS IN CHILD WELFARE SINCE 1950

The definition of "child welfare" used in this chapter is broader than the services provided under the Child Welfare Act. In addition to reviewing children's aid societies' role in child welfare between 1950 and 1980, this chapter presents statistics and trends related to a group of children's institutions that were governed for most of the period by three other statutes, the Children's Institutions Act, the Children's Boarding Homes Act and the Charitable Institutions Act (the institutions for miscellaneous purposes). The chapter is organized in sections that review the societies' role in residential care and in the community, inter-service stream issues, and the role of the children's institutions and children's boarding homes in residential care. It concludes by summarizing the broad trends in child welfare services during the period under consideration.

Residential Care Provided by The Children's Aid Societies

The province's present system of children's aid societies was established following passage in 1893 of An Act for the Prevention of Cruelty to, and better Protection of Children, which gave voluntary societies broad powers to remove children from neglectful parents, and accepted foster care as the preferred method of caring for these children. Passage of the legislation was due in large part to the efforts of J.J. Kelso, the social reformer who was appointed superintendent of neglected and dependent children to implement the legislation. Kelso was an ardent advocate of foster care and, as a strong critic of institutions, called for their closure. In his 1897 annual report, Kelso wrote:

> ...I fear that in many instances the children are lost sight of, and the rules, regulations and plans for the aggrandizement of the institution placed far above the interests of the little boys and girls whose hearts crave for a real home, a real mother and a real, instead of artificial, system of work and play (Jones & Rutman, 1981, p. 83).

Several themes of provincial concern tend to reappear over the years in the annual reports of the Ministry of Community and Social Services and the departments that preceded it. Broadly, these have been to encourage adoption and foster care as alternatives to residential care as well as measures to keep families together.

A shift in emphasis to service to children in their own homes was already apparent at the start of the period under consideration in this paper. Although this discussion begins with trends as of 1950, it is important to note that annual reports prior to that year described children's aid societies as making every effort to re-establish or maintain a home, rather than remove the child. For example, the 1947-48 report stated:

> While there are still persons who believe that a major role of the Children's Aid Societies is to remove children from their own home and place them in a new environment, the Societies increasingly emphasize the importance of keeping the child's own home together. The governing principle is that only after all other measures have failed, should the child be removed from its own home. Even then, many children are given temporary care only, until other means are found to re-establish them with their own families (p. 13).

The effect of this policy of the societies over the years from 1950 to 1980 is shown in Table 2. Despite considerable population growth, the number of Ontario children in the care of the societies was lower in 1980 than in 1950, and the proportion in the care of societies dropped during the period from 1.3% to .5%.

Table 2

Children in the Care of Children's Aid Societies

	1950	1960	1970	1980
Children in Ontario under age 18	1,362,000	2,205,300	2,635,000	2,414,300
Children in society care at end of year	18,355	14,188	17,807	13,033
Rate of society care per 100,000 children under age 18	1,347.7	643.4	675.8	539.8
Per cent of children under age 18 in society care	1.3	.6	.7	.5

Source: 1. Statistics Canada Catalogue No. 91-518: intercensal estimates of the population by sex and age for Canada and the provinces.

2. Annual reports of the Department of Public Welfare (1950-51 and 1960-61); the annual statistical report provided by societies (1970 and 1980).

The mix of resources used by societies to provide alternative care for children removed from their families has varied over the years. Table 3 very clearly shows the increasing proportion of care paid for by societies and a corresponding drop in "free" care (i.e., care for which societies incur no direct cost, since there is no charge, as in adoption, or the cost is borne by taxpayers, as with children's mental health centres).

Table 3

Types of Care Provided Children in the Care of Societies

(Per Cent)

Type of Care	1950	1960	1970	1980
Paid care:				
- CAS residential(1)	1.9	2.0	5.4	9.6
- foster home	49.3	65.4	62.9	54.6
- outside residential(2)	2.4	4.6	5.8	12.8
Total	53.6	72.0	74.1	77.0
Free care:				
- free homes	14.0	6.0	1.6	2.8
- adoption	28.5	16.3	17.8	10.0
- other	3.9	5.7	6.5	10.2
Total	46.4	28.0	25.9	23.0
Number of children in care at year end=	(18,355)	(14,188)	(17,807)	(13,033)

1. Data for 1950 and 1960 include only society receiving centres, while later data include society-operated group homes.

2. This category includes care provided by child care institutions and group homes operated by others than societies.

Source: Annual reports of the Department of Public Welfare (1950-51 and 1960-61); the annual statistical report provided by societies (1970 and 1980).

In the declining free care category, adoption shows the largest drop, with the use of free homes declining less but more dramatically. In 1950, the "other" category under free care was made up of three groups: Ontario hospitals (1.6%), correctional institutions (1.3%) and "elsewhere" (1.0%). By 1970, while the proportion in Ontario hospitals remained relatively steady (1.3%), correctional placements were no longer counted, because that wardship superseded societies' forms of wardship. In addition, a new category, "home of parent", had appeared, serving 3.5% of the children in the care of societies.

Within the increasing proportion of paid care, outside paid residential shows the largest increase, with the number of children involved increasing from 442 to 1,662, or by 376%. The development appears to reflect a sharp increase in the usage of children's boarding homes in the latter 1970s. Society-operated group homes also played an increased role in residential care, serving 3.6% of the children in care in 1970 and 6.8% in 1980. Foster care, the most used form of residential care, peaked during the 1960s, and accounted for fewer children in care in 1980 than in 1950.

In the early 1950s, with a large number of children in the care of societies and costs increasing, the Minister appointed a committee to review child welfare issues, and another committee to recommend changes in three existing pieces of child welfare legislation, the Children's Protection Act, the Children of Unmarried Parents Act and the Adoption Act. The first committee reported that the number of children in paid care was excessive and neither socially nor financially desirable. It called for increased protection and adoption efforts and a new basis for provincial grants to societies.

The committee on the legislation recommended that provincial grants be made for preventive services (i.e., counselling or casework services to families on the protection caseload aimed at preventing children coming into care) and a uniform formula for providing children's maintenance. These and other recommendations were subsequently reflected in new, unified legislation, the Child Welfare Act, 1954.

With the new Act, the Government accepted direct responsibility for supervising the operations and ensuring the accountability of the children's aid societies. In a 1949 amendment to the Children's Protection Act, the province had undertaken to reimburse municipalities for 25% of child maintenance costs. The 1954 Child Welfare Act continued this provision, and in addition, established a system of annual provincial grants to the societies. A 1957 amendment raised the provincial share of child maintenance costs to 40%.

By 1959-60, the annual report noted with some satisfaction that:

> With the help of directly focussed provincial grants, the Societies have placed more emphasis on the provision of services to children in their own homes forestalling thereby, in many instances, the need to remove them as neglected children. That the number served in their own homes has risen over the period by 15% from 40,000 to 46,000 children, and that the number taken into public care has fallen by 18% from 27,000 to 22,500 per year is, at least in part a reflection of the changing approach (p. 15).

To efforts to increase adoptions, the report ascribed "a reduction of 45% over the past ten years in the proportion of the child population who spend some time during the course of a year in the physical care of a Children's Aid Society" (p. 15).

However, the report also stated that although the proportion of the child population in the care of societies continued to decrease, the average length of stay continued to increase. This was related to the observation that children in care required increasingly specialized, intensive and expensive care including more institutional settings (p. 16). In consequence, the cost of child welfare services to the individual taxpayer was seen as increasing (p. 17). The 1963-64 report also commented that fewer children were in care, but those remaining were more difficult, and needed specialized residential services (p. 4).

Reporting in 1964, another ministerial advisory committee on child welfare recommended a further emphasis on prevention and changed funding arrangements. Incorporated in the Child Welfare Act, 1965, these changes became effective in 1966. Under the new Act, the Province directly funded society budgets by paying a 40% share of approved estimate of most society operating costs(1). In 1967, the provincial share was raised to 60%(2). This new funding arrangement facilitated both a greater use of residential care and the expansion of protection services. The 1966-67 departmental report stated that admission of children to care increased by 11%, and identified societies for the first time as developing their own group home resources. These were used for 315 children (p. 2). In addition, 1966 showed an increase of 42% in protection services (1967-68 report, p. 2).

By 1970-71, the major expansion of services encouraged by the funding change and the federal cost sharing of child welfare services under the 1966 Canada Assistance Plan Act(3) had peaked, and a decline in both residential service and the child population in Ontario had begun. Thus the 1970-71 report identified 4% fewer children admitted into care and a 12.5% decrease in protection cases in comparison with the previous year (p. 6). Nonetheless, the number of children in societies' own group care had increased to 648 children (3.6%) in 1970 from 315 (1.9%) in 1966. Outside paid institutions also had increased from 708 children in care (4.3%) in 1966 to 1,027 (5.8%) in 1970.

During the years from 1968 to 1975, the Child Welfare Branch undertook annual surveys of societies' practices that consisted largely of statistical and case reviews. With the rapid increase in outside paid care and the expansion of societies' own group care, these placements were included in the annual reviews. The reviews considered such factors as the decision process leading to a placement, what type of plan was recorded and the frequency of the review. The intent was to ensure that placements were the outcome of sound planning and subject to ongoing, thorough monitoring. The annual survey reports do not evaluate these efforts, although they provide some statistical information on the placements.

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1. The Province paid 100% of the approved estimates of the costs of care and maintenance of the children of unmarried mothers.

2. The provincial share of societies' approved estimates was raised to 80% in 1975.

3. Under the Canada Assistance Plan, funds flowed from the federal government to the provinces for services providing assistance to persons defined as being "in need". Many services became eligible for the 50% federal cost sharing. The costs that were shared included:

   - general assistance, covering basic requirements of individuals and families...and as well special needs deemed necessary for the safety, well-being and rehabilitation of persons in need

   - the cost of operating homes for special care, such as homes for the aged, nursing homes and welfare institutions for children

   - costs of child welfare programs, including contributions to the cost of child protection, adoption services and care in foster homes, group homes and specialized institutions

   - welfare services, having as their objective the lessening, removal or prevention of the causes and effects of poverty, child neglect or dependence upon public assistance, including rehabilitation services, casework, counselling and assessment services, homemaker and day care services, and community development.

The Branch published the results of the 1973 survey of outside placements. A 38% sample of the case files of the 1,048 children in outside paid care as of December 1973 (398 files) was reviewed.

The 1973 survey reported on various dimensions, including the type of service the facility was expected to provide. The type of service was divided into care and treatment, which were subdivided into short- and long-term, although definitions were not recorded. The survey findings with respect to service expectations are shown in Table 4.

Table 4

Type of Service Expected of the Outside Paid Care Facility

	No. of Children by Type of Service	Per Cent of Children
Care:		
Short-Term	18	4.6
Long-term	118	30.2
Treatment:		
Short-term	38	9.7
Long-term	217	55.5
Total	391(1)	100.0

1. The total is less than 398 because "no record" entries were excluded from the total.

Source: Supplement to 1973 survey (Children in Paid Institutions Information Tabulated for 50 Societies in 1973).

These findings support statements in the annual report that the various residential resources were facing increasing demands for treatment of more difficult children and that these placements were seen as needing longer periods of residential service.

During the 1970s, the Ministry's annual reports reduced both their overview comments and their statistical content. The two most dominant themes were adoption efforts and the changing age groupings of children admitted to and in care. With an increasing number of older children in care, a number of the reports noted that significant numbers were more difficult to manage and therefore more expensive to care for. The following table illustrates the changing age distribution of children in care.

Table 5

Age Distribution of Children in the Care of Societies

(Per Cent)

Age	1966	1970	1975	1980
Under 5 years	42.4	34.5	20.7	20.8
5 to 12 years	32.6	32.4	29.8	28.0
13 to 17 years	23.1	28.7	45.7	46.3
18 and over	1.9	4.4	3.7	4.9
No. of children in care at year end	(16,487)	(17,807)	(13,904)	(13,033)

Source: See Table 3.

Child Welfare Services in the Community

Over the years, child welfare services in the community have been shaped by two major currents in social work practice. One has been an emphasis on the importance of meeting the psychological as well as the physical needs of the child. The other has been recognition of the extent of the problem of child abuse and its various manifestations.

Attention to the importance of the psychological needs of the child was already evident by 1950 in the efforts by children's aid societies, noted in the previous section, to maintain the child within his own family wherever possible. In 1960s and 1970s, this view in the social work field was reinforced by a growing body of research including long-term studies of foster care carried out by the Child Welfare League of America and by writings such as those of the American-British team of Goldstein, Freud and Solnit. In their influential Beyond the Best Interests of the Child (1973), they asked how

> can the law assure for each child the chance to become a member of a family where he feels wanted and where he will have the opportunity, on a continuing basis, not only to receive and return affection, but also to express anger and to learn to manage his aggression? (pp. 5-6)

and argued that

> The law must make the child's needs paramount. This preference reflects more than our professional commitment. It is in society's best interests. Each time the cycle of grossly inadequate parent-child relationships is broken, society stands to gain a person capable of becoming an adequate parent for children of the future (p. 7).

Although suspicious injuries in infants had been noted earlier, it was not until the mid-1950s that medical literature recognized that these were deliberately inflicted by abusive parents and other caretakers. Initially, it was the phrase "battered child syndrome", the title of a paper presented at a 1961 medical symposium and published the following year (Kempe et al, 1962), that caught professional and popular interest in North America and elsewhere. Subsequently, "child abuse" became the subject of extensive investigation and a specialized area within child welfare. In the United States, the federal Department of Health, Education and Welfare published model legislation, and from 1963 to 1967, all 50 states adopted some form of child abuse reporting statute (Farina, 1982, pp. 164-167). While the Criminal Code of Canada and existing Ontario child welfare legislation prohibited deliberate cruelty to children, the Ontario provisions were revised and strengthened in the 1965 Act. A provision for the reporting of child abuse was added in that year, and this became a mandatory requirement for professionals in 1978, when the legislation underwent major revision.

The 1978 Act also strengthened the focus on the child's needs. Under the current legislation, a children's aid society appearing in a wardship action is expected to give evidence about the support it has provided to help a family keep a child at home before taking the child into care. In addition, the Act requires planning related to the needs of the child once in care, and provides for an annual review of the status of every child who has been a Crown ward for a continuous period of two years and a review every two years thereafter.

The discussion below reviews trends in these services to children and families in the community:

- protection and prevention services
- services to unmarried mothers
- adoption services.

Protection and Prevention Services

Children's aid society data on protection and prevention services provided to children in their own homes are not broken out in such a way as to reflect the broadening of the concept of prevention over the years or the specific types of preventive services provided, such as homemakers and counselling. However, Table 6 gives some idea of the effect of the expansion of protection and prevention services in recent years on total children's aid society caseloads.

Table 6

Protection and Prevention Services

Year	Cases Carried Over	New Cases	Reopened Cases	Total Open Cases	Cases Closed	Cases Carried Forward	Per Cent Change
1950	8,727	9,953	N.A.	18,680	9,597	9,083	-
1960	7,453	9,144	2,117	18,714	11,044	7,670	- 15.5
1970	11,310	11,084	5,043	27,437	15,857	11,580	+51.0
1980	22,060	18,121	8,308	48,489	27,195	21,294	+83.9

1. A possible change in reporting between 1954 and 1955 may account for the decline in new cases and the minimal increase in total cases between 1950 and 1960. New and total cases were both rising in the early 1950s.

2. A change in the definition of brief services has contributed to the marked increase in protection counts between 1970 and 1980.

Source: See Table 3.

The growth of protection and prevention services was most striking during the past decade. Although the child population aged 15 or under declined an estimated 11.7% between 1970 and 1980, protection and prevention cases open during the year rose 76.7%, and cases open at the end of the year nearly doubled.

The 63.5% increase in the number of new cases over the decade is one indicator of the efforts made by the societies to avoid bringing children into care at the outset. The 64.7% increase in reopened cases appears to reflect not only a trend to keep children in care for short periods, and return them to their families as soon as possible, but also crisis intervention aimed at preventing admission to care.

Citing unpublished Ministry statistics, Hepworth (1980) notes that from 1960 to 1977 the number of children who received protection services before transfer to in-care services rose from 3,718 to 8,450 and from 49% to 72% of admissions to care. On the other hand, admissions to care remained relatively stable both in number and, in contrast to the situation in other provinces, as a proportion of the total child population. In 1961, according to Hepworth, Ontario had the highest proportion of its child population admitted to care of all the provinces, but in 1976, ranked fifth highest (pp. 43-45).

> It could be argued that protection agencies are growing less effective because proportionately more of the children are subsequently admitted to care. It could also be argued that more admissions to care are now planned admissions after protection services have been tried but found to be ineffective...On the discharge side a growing proportion of children receiving protection services have been transferred from in-care services; in other words, the discharge process is a planned and phased process in which the child welfare services continue to maintain surveillance after a child has been in care. It seems fairly certain, therefore, that the protection services do serve to regulate the flow of children into and out of care (p. 45).

Services to Unmarried Mothers

Table 7 shows a peak in societies' services to unmarried mothers in 1970 and a subsequent sharp decline.

Table 7

Services to Unmarried Mothers

Year	Cases Carried Over	Total Intake	Total Open Cases	Cases Closed	Cases Carried Forward	Per Cent Change
1950(1)(2)	4,690	3,532	8,222	3,662	4,560	-
1961	3,785	5,963	10,239	6,232	4,007	-12.1(1)
1970	5,318	9,071	14,389	9,748	4,641	+15.8
1980	2,300	2,753	5,053	2,996	2,057	-55.7

1. Figures for 1950 do not include the then two Toronto societies.

2. Unmarried mothers are not shown separately from putative fathers in the 1950 data.

Source: See Table 3.

Other society data show that the number of children retained by mothers receiving unmarried parents' service rose from 2,094 in 1966 to 4,470 in 1970, but declined to 1,442 in 1980.

The declining birth rate - among mothers aged 19 and under as well as other age groups - is only a partial explanation of this decline in services to unmarried mothers, although births to unwed mothers in Ontario peaked in 1970 (Guyatt, 1974, p. 2). Societal attitudes towards unmarried mothers have changed. It has become more acceptable in moral and philosophical terms for an unmarried mother to keep her child. Also, it has become easier for her to get public assistance. In addition, fewer unmarried mothers are approaching the societies for service (op. cit., p. 9). The unmarried mother may be seeking and getting support from other organizations than the children's aid society, such as a YWCA, a neighbourhood resource centre, a well-baby clinic or the local public health department. She may view the society as a placement resource, giving priority to placing babies for adoption. Further, again citing unpublished Ministry statistics, Hepworth notes a sharp drop both in the numbers of children of unmarried parents admitted to care and such children admitted after receiving protection services and in these admissions as a proportion of total admissions to care (Hepworth, op. cit., p. 43).

Adoption Services

Adoption as a permanent means of establishing children within a family setting received legal status in 1921, and increased in public acceptance steadily until World War II, when it gained a new impetus as servicemen sought to complete adoptions of children before going overseas(4). Subsequently, the previously cited efforts of the children's aid societies to increase adoptions, coinciding with the rise, particularly in the 1960s, in births to unmarried mothers, resulted in a sharp increase in society-placed adoptions. Since 1970, the concerted effort by the societies to return children in care to their families, together with the increasing trend for unmarried mothers to retain custody of their children, has resulted in an abrupt drop in society-placed adoptions, as shown in Table 8.

Table 8

The Flow of Children in Care

Year	Children in Care Returned to Parents or Guardian	Society-Placed Children on Adoption Probation
1950	2,289	N.A.(1)
1960	3,736	3,985
1970	5,978	5,394
1980	8,663	1,652

1. This record may be available in the archives. Information Centre has the provincial summaries only back to 1971.

Source: See Table 3.

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4. Annual report for 1944-45, p. 19.

While society-placed adoptions have declined overall, changing views about the possibility of adoption for older children, as well as the scarcity of infants, have led to adoption placement of a higher proportion of older Crown wards. The Ministry has encouraged this through adoption exchange meetings with society workers that provide informal professional education. Ministry-supported province-wide public information campaigns to find adoptive homes for hard-to-place children (those who are older, are of racial minorities, have handicaps or should be adopted with siblings) no doubt have also had a significant spill-over effect on public interest. The media used have included the Today's Child column begun in 1964, the Family Finder television program begun in 1969 and the Children's Bulletin. Also, the 1978 Child Welfare Act provided for adoption subsidy, previously available only through Order-in-Council.

Inter-Relationships with Other Service Streams

Table 3 provided an overview of society residential placements showing that societies used a number of "outside" resources. The distribution of children in the care of societies among various residential resources as determined by the 1973 placement survey is shown in Table 9.

Table 9

Legislation Under Which Children Were Placed in Outside Paid Care

Act	No. of Children	Per Cent
Children's Institutions	63	15.8
Charitable Institutions	5	1.3
Children's Boarding Homes	299	75.1
Homes for Retarded Persons	31	7.8
Total	398	100.0

Source: Supplement to 1973 survey.

It is noteworthy that placements in children's boarding homes far outstripped those with children's institutions or charitable institutions. The Children's Boarding Homes Act did not have the same funding limitations as the children's institutions and charitable institutions and so facilities under it were able to expand much more rapidly to meet the demand for placements. Many children's boarding homes were established with the support of societies, some with former society staff, and their programs were tailored to the needs of children in the care of societies.

Although the placements in homes for retarded persons suggest a low proportion of mentally retarded children in society care, the reasons for admission to outside paid care, shown in Table 10, demonstrate that mental retardation was a significant factor in society placements. (The role of children's boarding homes in serving mentally retarded children is further discussed on pages 45 and 46 of chapter 4, where it is noted that the proportion of the children in the care of societies who were retarded in 1971 was estimated at 30%.)

Table 10

Reasons for Admission to Outside Paid Care

Reason	Number	Per Cent
Behavior/emotional	300	63.6
Retarded	126	26.7
Multiple problems	30	6.4
Other	16	3.4
	472(1)	100.1(2)

1. The total exceeds 398 because more than one reason was recorded for some children being placed in paid care.

2. The total exceeds 100% due to rounding.

Source: Supplement to 1973 survey.

The large number of society placements of retarded children provides an example of the existence of multiple placement routes and overlaps between the various service streams. It suggests also how policy decisions in one service stream may increase placements in other streams. Following the decision to "deinstitutionalize" services for developmentally handicapped people (which is dealt with in the overview of the developmentally handicapped stream in chapter 4), parents found placements more difficult, with the result that more children were found to be "neglected", and came into the care of societies.

More recent data on mentally retarded children in society care are provided by the Crown Ward Review Unit's report on the results of its first three years of operation. In reviewing a total of 4,650 Crown ward cases under the supervision of the 51 societies, the Unit found that "about one-seventh were mentally retarded, including 46 children with Down's syndrome. Many have a combination of mental and physical handicaps". In the absence of comparable data on the proportion of Crown wards who were mentally retarded in the past, it is impossible to be sure that it has declined. It appears likely, however, that the expansion of mental retardation services described in chapter 4 has resulted in a reduction in the proportion of mentally retarded children in the Crown ward caseload.

Similarly, inter-relationships exist between the child welfare and juvenile corrections streams. Repeal of Section 8 of the Training Schools Act, effective January 1, 1977 (discussed in greater detail in the next chapter), was implemented in the expectation that many of the so-called unmanageable children previously dealt with under that legislation would now be served under the Child Welfare Act. Since the number of children aged 13 to 17 years in the care of societies rose in 1977, and the percentage of these children in care peaked in 1979, it appears that this expectation was indeed realized.

Table 11

Children Aged 13 to 17 in the Care of Societies

Year	Number of Teens in Care at Year End	Per Cent of Total in Care
1974	5,886	42.9
1975	6,356	45.7
1976	5,886	45.4
1977	6,304	48.0
1978	6,551	47.4
1979	6,582	47.0
1980	6,036	46.3

Source: See Table 3.

Residential Care in Children's Institutions and Boarding Homes

The children's institutions in existence at the outset of the period under consideration included a number of facilities that were originally established under charitable auspices for broad child welfare purposes, but had begun to specialize in serving more difficult children. In 1950, 47 institutions for children were mandated under the Charitable Institutions Act. In addition to residential children's institutions, these included 11 homes for unmarried mothers and three child placement agencies (Catholic Welfare Bureau, Toronto Jewish Family and Child Welfare, and Protestant Children's Homes) that provided private boarding home care for children(5). In 1980, as the result of closures of a number of the larger children's institutions and development of smaller, more specialized programs, there were 60 children's institutions in operation, including 11 maternity homes. By the end of this period, the small, relatively new facilities known as children's boarding homes were serving more children than children's institutions.

The earliest children's institutions were established to care for orphans and neglected children in the 1850s, well before the children's aid societies. "Although organized with the apparent purpose, in most instances, of caring for children only until such time as they could be apprenticed, these institutions tended to develop programmes for the long-term care of children", according to Splane (1965, p. 225). The inward-looking, institutional focus of these facilities was in contrast to the children's aid societies' preference for using foster care for long-term care of children. For much of their history, the institutions served large numbers of parentless and neglected children, particularly during such times of social disruption as the Depression and World War II. They also served children placed on a voluntary basis by parents who were unable to care for them temporarily or for extended periods. Donations were their primary source of funding, and government support was very limited.

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5. Annual report for 1950-51, p. 19.

By the latter 1940s, the children's institutions were being used to meet a wide range of needs of children from custodial to temporary and specialized care. The Ministry's annual report for 1947-48 noted that "institutions are expanding the specialized services provided for children. A certain number are continuing to care for the unmarried mother and her child until the latter is placed. Certain institutions are providing special care for emotionally disturbed children" (p. 25).

According to the annual report for 1949-50,

> The great majority of children in children's institutions either had both parents, or at least one living parent but for many reasons, these parents were unable to give their children the type of care they needed. As a consequence, they were admitted into an institution for a temporary period. During that time they were provided with a constructive experience in group living in order to enable them to fit comfortably and happily into family life, or if necessary, into the life of a permanent foster family (p. 18).

Subsequent annual reports noted a continuing decline in the care of the normal child. "Recognizing the need of children for family life, many institutions which formerly cared for infants and pre-school children, are seeking a more specialized purpose. Several have undertaken the care and treatment of emotionally disturbed youngsters who cannot fit into family life", stated the annual report for 1955-56 (p. 54). This care, it was noted, had proved more costly than care for the normal child.

A concern for standards of care as well as recognition of the rising cost of residential care resulted in several new pieces of legislation in the following years. Under a new Charitable Institutions Act passed in 1956, charitable organizations were given provincial grants to construct new facilities and expand programs for children, youths and unmarried mothers as well as the elderly.

In 1957, after a lengthy controversy over a notorious "baby farm" operation, the Children's Boarding Homes Act was passed. This, according to the annual report for 1957-58, "was designed to safeguard the welfare of children placed by their parents in boarding homes, offering group care to children from five or more families" who were normal, mildly disturbed, retarded or mentally handicapped (pp. 22-23). The report for 1963-64 noted that "this Act in a indirect way has provided a formal means of regulating an otherwise chaotic area of dubious private enterprise and has reduced the number of children's boarding homes operating on a fly-by-night and haphazard basis" (p. 3). Thus in the first year under the Act, there were 15 boarding homes, and this number had only increased to 37 by 1970. By 1980, however, there was a total of 269 such homes in the province with a capacity of 2,012 beds, as shown in Table 12. The average size of the boarding homes had dropped sharply.

Table 12

Capacity of Children's Boarding Homes

	No. of Homes	Capacity	Average No. of Places per Home
1957	15	N.A.	-
1965	9	117	13.9
1970	37	380	10.3
1975	120	1,200	10.1
1980	269	2,012	7.5

Source: Annual reports of the Department of Public Welfare (1957-58 and 1965-66), the Department of Family and Social Services (1970-71) and the Ministry of Community and Social Services (1975-76); Child Advocacy Information System data as of 1980.

While this Act provided a licence for boarding homes, it did not include a mechanism for direct funding by the Government of the operation of their programs. Children's aid societies mainly purchased the service of the boarding homes on a per diem basis. Therefore, the homes, not being constrained by a set funding base, were able as indicated above to expand rapidly to meet the demand for placements. The creation of these smaller units facilitated the provision of individualized care in more family-like settings.

The shift towards the use of institutions for specialized care was reinforced in 1963 with the passage of the Children's Institutions Act, which provided funding mechanisms for residential care. This legislation reflected recommendations in the 1961 report of a provincially appointed Committee to Study Standards for Children's Institutions. The Act separated children's institutions from adult institutions, and categorized them according to the type of service provided as well as changing principles of subsidization. Children's institutions operated by approved charitable organizations were classified into three categories or schedules:

- Schedule II: residences for board, lodging and supervisory care
- Schedule III: residences offering programs for children who, on the basis of psychological and medical findings, have difficulty in adjusting or benefitting from normal family relationships or in adjusting to or coping with regular community life
- Schedule IV: residences giving specialized treatment for emotionally disturbed children(6).

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6. Turner, P. Operational Review: Children's and Youth Institutions Final Report. Ministry of Community and Social Services, May 1979, p. 16.

The legislation also recognized the child care work profession and post-graduate social work education, and established staff-child ratios.

Describing the legislation, the annual report for 1963-64 said that "the new Act and its regulations helped to raise the physical standards required in children's institutions, sharpened the requirements for medical and treatment services and has, in essence, heralded a new day for children's institutions in this province" (p.3).

The legislation caused some of the large institutions to close because they could not meet the new standards. About 500 beds closed permanently. Meanwhile, taking advantage of capital grants offered under the Act, other institutions built new and smaller facilities.

As a result of the legislation:

- Facilities were upgraded so that many of the institutions were better able to offer specialized services such as care for emotionally disturbed children.
- Professional development of program staff and administrators was encouraged to better serve the new clientele.
- Fewer children were served, requiring the institutions to be more selective in choosing those who were in most need and could benefit from institutional care.
- The average length of stay for those taken into care increased.

In 1963 also, the Homes for Retarded Children Act was passed to provide assistance and regulation for homes specifically operated for the care of these children.

With costs rising, funding under the various Acts was increased during this period. Funding under the Charitable Institutions Act, which continued to cover homes for unmarried mothers and a number of child and youth institutions, was raised from 50% to 75% of the allowable per diem rate in late 1962. The Children's Institutions Act and the Homes for Retarded Children Act were amended in 1965 to allow an increase in capital grants and an increase in operating grants from 50% to 75% of allowable per diems. In 1966, grants for facilities under the Children's Institutions Act and the Charitable Institutions Act were raised to 80% of allowable per diems, as were grants to homes for retarded persons under amended legislation that now applied to adults' as well as children's facilities.

These legislative amendments, which encouraged residential care for specialized treatment purposes, resulted in an initial increase in the number of children admitted to the institutions. In 1950, an estimated total of 5,300 children were served, as shown in Table 13. In the following decade, this figure dropped by 50.3% to 2,635. Between 1960 and 1970, it rose by 9.4% to 2,883, in a decade when the child population grew by 19.5%. By 1980, however, the number of children served in the institutions had declined, as reported by the Child Advocacy Information System, to 2,099 (a figure that probably errs on the low side, because the system came into operation during 1980).

Table 13

Children Served(1) in Institutions and Boarding Homes

Year	Child Residents in Institutions	Per Cent Change	Children in Boarding Homes	Rate per 100,000 Children Under 18
1950	5,300(2)	-	-	389.1
1960	2,635(3)	-50.3	N.A.	-
1970	2,883(4)	+9.4	380(5)	123.8
1980	2,099(6)	-27.2	2,749(7)	200.8

1. Children in residence at the beginning of the year plus those admitted during the year.
2. Figure is approximate, and includes residents of all institutions for children. Source: annual report for 1950-51.
3. Figure includes residents of children's institutions and mothers aged 18 or less in maternity homes. Source: annual report for 1960-61.
4. Figure includes residents of children's institutions (Schedules II, III and IV), charitable institutions and homes for retarded children aged 17 or less and mothers aged 18 or less in maternity homes. Source: annual report for 1970-71, statistical supplement.
5. Approximate capacity of the homes. Source: annual report for 1970-71.
6. Figure includes residents of children's institutions aged 17 or less and residents of maternity homes aged 18 or less. Source: the Child Advocacy Information System.
7. Children aged 17 or less. Source: Child Advocacy Information System data as of September 1981.

A comparison of the declining figures for children served in institutions with the growing numbers in children's boarding homes - 2,749 in 1980 - suggests that much of the growth of the homes was a result of their greater funding and program flexibility. Because the boarding homes were not guaranteed funding, they had to sell their services by responding to requests for individualized programming in order to continue in operation. Despite the increase in children served in boarding homes, the total number of children served in institutions and children's boarding homes combined in 1980 was lower, at 4,848, than the number of children served in institutions in 1950. The overall rate of residential care in these facilities in 1980 was just over half the 1950 rate. It should be noted, however, that in 1980, the fully funded children's mental health system (discussed in detail in chapter 5) reported more than 1,900 incidents of residential service to children.

The more generous funding formulas introduced in the 1960s helped accelerate changes and further promoted the specialized institutional orientation. Development of residential facilities, according to the annual report for 1965-66, became even more attractive to individuals and corporate groups. "With the additional financial assistance available, institutions...are now in a position to admit more privately placed children," the report observed. "The increase in construction grants has stimulated interest among various groups and organizations throughout the Province in providing new and expanding institutional facilities for children requiring specialized services. Over thirty enquiries have been received and at the end of the year several corporations had progressed to the point of making formal application for a grant. These homes as they develop will in time help relieve the present shortage of beds for children requiring institutional care" (p. 4).

In response to this new interest in expanding residential facilities, a separate Children's Institutions Branch, formerly only a unit within the Child Welfare Branch, was established in 1970. "The scope of the new Branch is wide, and includes the supervision of institutions which care for homeless and handicapped children, and young people with various problems, retarded persons, unmarried mothers, and youngsters with acute personal problems who are unable to live at home," noted the annual report for 1969-70. "The establishment of the new Branch reflects the growing importance of specialized residences for children and young people" (p. 15).

The increased ease of private placements, together with the promotion of residential care facilitated by passage of the 1965 Child Welfare Act, resulted in an increase in the number of children being served in children's institutions, charitable institutions, homes for retarded children and maternity homes, reversing the trend of the previous decade. Thus this is another example of policy decisions in one part of a service stream affecting service delivery in another part.

Similarly, the decline in the total number of children served in the institutions between 1970 and 1980 reflects not only the growth of children's boarding homes, but also the creation in 1971 of the fully funded children's mental health system. (A number of Schedule III and Schedule IV facilities became children's mental health centres under the new Children's Mental Health Centres Act in 1971.)

The period from 1965 onwards showed a shift as well in the pattern of referral sources of children placed in the range of institutions. Up through 1965, children's aid societies were the major source of referrals to institutions, exceeding 55% in 1960. Following in descending order were parents, "other" and other agencies. In contrast, from 1967 onwards, the major referral source was "other", followed by parents. The children's aid societies were ranked third overall. By 1970, society referrals accounted for less than 20% of referrals. Even fewer referrals were from other agencies, although their share was rising.

The decreasing number of children, particularly wards, referred from children's aid societies for outside institutional care meant that children's institutions received less full-pay revenue. Instead, a greater proportion of their revenue was part-payments from parents and others (e.g., grants from municipalities). However, this source of funding resulted in fewer dollars being flowed to institutions; the institutions were expected to raise 20% of the cost of providing care from parents and charitable donations, whereas children's aid societies were responsible for 100% of per diem costs for society-placed children. The implication of this shift was that institutions were less able to develop programming, or respond to requests for more individualized programs.

A change in funding arrangements to alleviate the resulting decline in service was a key recommendation of the operational review of the institutions that concluded in 1979 (Turner, 1979). In 1980, the regulations under the Children's Institutions Act were amended to allow for up to 100% funding through negotiated agreements for the provision of services.

Two other trends resulting from the emphasis on specialized residential care are worth noting. These are shifts in the predominant age group and sex of the children in care.

The age of the clientele shifted from children less than 14 years of age, and more often less than nine years of age, to mainly youth older than 14 years of age. In the latter 1950s, more than 70% of the clientele of the children's institutions were less than 14 years old. The age pattern started to change around 1960, and by 1968, children over 14-year- olds were in the majority. After that, the institutions' clientele were primarily adolescents. (From that time on, the institutions also served increasing numbers of young persons over 18, a population that is not being tracked here.) In 1980, 66.3% of the children served by institutions were between 14 and 18. In children's boarding homes, 73% of the children served in 1980 were between 14 and 18.

As these residential facilities were serving more adolescents, fewer adolescents were being sent to training schools, a trend reflected in training school closures during the 1970s that will be discussed in the next chapter. Many of the youth who were admitted to these facilities in the late 1970s would have gone previously to training schools and correctional group homes.

In 1953, approximately 60% of the institutions' clientele (maternity homes excluded) was female, but by 1957 males were in the majority. In 1980, 54.3% of the clientele was male. Over 69% of the clients of children's boarding homes in that year were male.

Summary of Trends in Child Welfare

The major trends in child welfare services from 1950 to 1980, encouraged by provincial policy and funding, were as follows.

- The children's aid societies continued to favour adoption and foster care as alternatives to long-term residential care for children removed from the care of their parents, and placed increased emphasis on services to maintain children in their own families.
- The children's institutions increasingly shifted from the provision of long-term custodial care to specialized services for emotionally disturbed children.
- Both systems served an older and more disturbed but smaller residential clientele.
- Children's boarding homes expanded rapidly to provide service to troubled adolescents and mentally retarded children in smaller, community-based settings.

At the end of the period, the rates of residential care through child welfare services were lower than these had been in 1950, as shown in Table 14.

Table 14

Residential Care Through Child Welfare Services: Rates per 100,000 Children Under 18

	1950	1980
Children's Aid Societies(1)	1,347.7	539.8
Children's Institutions and Children's Boarding Homes(2)	389.1	200.8
Overall rate	1,736.7	740.6
Per cent of child population under 18	1.7	.7

1. Based on number in care at year end.

2. Based on total served during year.

Source: See Tables 2 and 13.

3. CHANGES IN THE JUVENILE CORRECTIONS SYSTEM

As in other sectors of children's services, the 25 years following World War II were a time of expansion of institutional facilities. Questioning of the appropriateness and the effectiveness of the existing correctional approach that took place during the same period led to legislative changes, the development of community alternatives to training school programs and the closing of much of the training school system. The historical background of juvenile corrections in Ontario, the children served by the correctional system, the growth and contraction of the residential capacity of the system, and the corresponding increase in community alternatives are described in the sections that follow.

It should be noted that responsibility for juvenile correctional services was historically dispersed among several ministries and consolidated within the Ministry of Community and Social Services only in 1977. Juvenile correctional services facilities currently comprise training schools, correctional group homes, probation and aftercare, (formerly the responsibility of the Ministry of Correctional Services), and observation and detention homes (formerly the responsibility of the Ministry of the Attorney General). As a result of changing methods of collecting and reporting data, comparability of data is a problem in some areas. The text highlights statistics that should be approached with caution.

From "Parens Patriae" to the "Labelling Theory"

During the 19th century and for most of this century, the juvenile corrections system in Ontario served child welfare as well as correctional purposes. Training schools were seen as a means of dealing not only with children who had committed offences that would be considered criminal if committed by adults but also with children whose "unmanageable" behavior posed a threat to both the community order and their own futures.

Historically, the mixing of child welfare and delinquency cases is traceable to an almost complete lack during most of the 19th century of a child welfare system to deal with either neglect or pre-delinquency (Grant, 1982, p. 33). Legislation to establish "industrial schools" for petty offenders (as distinct from those seen as requiring a reformatory) preceded the Children's Protection Act of 1893 by nearly a decade, and subsequently was amended to provide for the admission of children who had proved unmanageable for children's aid societies or their foster homes. Also, under the 1908 federal Juvenile Delinquents Act the juvenile delinquent was to "be treated, not as a criminal, but as a misdirected and misguided child, and one needing aid, encouragement, help and assistance". This Act provided the juvenile court with several possible dispositions, including probation, foster home placement and committal to a children's aid society or an industrial school.

The basic principles underlying the juvenile justice system and therefore the juvenile corrections system have been "parens patriae", or "the right of the state to intervene in lives of dependent children" and the "medical model" of delinquency. "The juvenile court...has in essence been a non-adversarial judicial proceeding in which the judge administers the precept of parens patriae". In the medical model, delinquent acts have been perceived as stemming "from underlying emotional, psychological and social pathology, most frequently deriving from the abuses of neglect, abandonment and an indigent environment. The function of the juvenile court therefore was seen as a means to identify and root out this 'sickness' " (Grant, 1982, pp. 66-67). Thus the juvenile justice system was regarded as beneficial to the children brought into it.

Effective in phases starting in 1984, however, the Juvenile Delinquents Act will be replaced by the Young Offenders Act, which treats the young person who commits a criminal offence as having greater responsibility for his actions, and provides for a range of sanctions, including sentences to training school of specific duration. Court proceedings under the new legislation are similar to those in adult court, providing the young person in conflict with the law with legal protections more like those provided to adults.

The legislative changes are the outcome of a general questioning of existing approaches to juvenile justice that began in the United States after World War II, and intensified during the 1950s and 1960s. "The essence of the criticism which was leveled at the juvenile justice system in North America was... that the juvenile court had failed to make good on its promise to act for the improvement of the delinquent child's welfare, and therefore the child and his parents had every right to demand the full protection of criminal due process which is afforded an adult who has been charged with a crime" (Grant, op. cit., p. 69). The value of the juvenile justice system was now sharply questioned.

In addition to the civil rights issue, much criticism of juvenile justice focussed on the use of large correctional institutions. In juvenile corrections, as in the children's mental retardation and mental health fields, a move to develop residential alternatives to large-scale institutional settings preceded the development of non-residential community programs. Much of the impetus behind both trends was the wide acceptance in the juvenile corrections field in the late 1960s and early 1970s of the labelling theory, which holds that:

- The process of defining a youth as a delinquent and treating him for delinquency "tends to stigmatize the youth and lead him into a deviant lifestyle".
- "The further a youth penetrates the juvenile justice system the more likely he is to stay in that system where treatment/intervention will be least effective" (Review of Community Alternatives to Training School, 1981, p. 3).

In Ontario, use of correctional institutions to deal with hard-to-control, often disturbed, but non-delinquent children was an additional cause for concern, finally resolved in 1977 through an amendment to the Training Schools Act that limited committals to delinquent children. By 1971, however, the availability of community alternatives made it possible for the courts to begin to reduce committals to training schools of both delinquent and non-delinquent children.

Children Served in Correctional Facilities

Until the 1970s, less than half of the children served in training schools were children who had been adjudged delinquent by the courts. The 1939 Training Schools Act still in effect at the beginning of the 1950s stated that the purpose of a training school was "to provide the boys or girls therein with a mental, moral, physical and vocational education, training and employment". The legislation provided for the admission to training schools not only of delinquents but also of children's aid society wards and "any other boy or girl one of whose parents or guardians consent thereto, unless there is no parent or guardian, and who in the opinion of the Minister is in need of the training and discipline offered by a training school". In effect, it was possible for any child aged seven through 15 who was considered unmanageable to be admitted to a training school through an administrative decision.

Between 1950 and 1970, the number of children admitted to training schools for the first time increased by nearly 150%, rising particularly rapidly after 1955, and peaking in 1970, as shown in Table 15. The changes in the rate of first admissions, based on population trends, were much less dramatic. This rate rose by 30% between 1950 and 1970, and declined by 51.3% between 1970 and 1980. With the increase in community alternatives, the number of admissions to training schools began to decline in 1971, although the decision to reduce the capacity of the training school system was not taken until 1972, and the amendment restricting admissibility to the schools to non-delinquents did not become effective until 1977.

Table 15

First Admissions to the Training School System

Year	No. of Children	Per Cent Change	Rate per 100,000 Children under 16	Per Cent Change
1950-51	576	-	46.6	-
1960-61	1,110	92.7	54.5	17.0
1970-71	1,428	22.7	60.6	11.2
1980-81	613	-57.1	29.5	-51.3

Source: Annual reports of the Department of Reform Institutions for 1950-51, 1955-56, 1960-61 and 1965-66; the Department of Correctional Services for 1970-71; the Ministry of Correctional Services for 1975-76; Juvenile Information System data for 1980-81; population statistics in Table 1.

(Since 1980, admissions to training schools have continued to drop, with first admissions declining to 570 in 1981-82.)

While first admissions to training schools nearly doubled between 1950 and 1960, unmanageability and truancy together accounted for more than half of the first admissions in both of those years, as shown in Table 16.

Table 16

Reasons for First Admissions to Training Schools
(Per Cent)

Reason	1950	1960
1. Unmanageable	49.3	45.3
2. Truancy	5.7	5.2
3. Theft	24.1(1)	21.5
4. Break and Enter	14.4	14.3
5. All other	6.4	13.6
	99.9(2)	99.9(2)
Number =	(576)	(1,110)

1. Category Includes auto theft.

2. Totals are less than 100% due to rounding.

Source: Part 2, Training Schools of the annual reports of the Department of Reform Institutions for 1950-51 and 1960-61.

In 1965, the Training Schools Act underwent the first major revision in a quarter of a century. The purpose of the training schools was restated as being "to provide the children therein with training and treatment and with moral, physical, academic and vocational education", thus introducing the concept of treatment as part of the schools' role. Admission to the schools was to be solely through the courts, a change that was seen as providing some measure of protection for the child's rights. However, Section 8 of the Act provided for admission by court order of any child under 16 years on "evidence that the parents or guardians of the child are unable to control him or to provide for his social, emotional or educational needs, and that the child's needs can best be satisfied in a training school rather than elsewhere". Section 9 provided for admission on "evidence that the child of at least 12 years of age has contravened a statute in force in Ontario which contravention would be punishable by imprisonment if committed by an adult", a wording that, it was argued, reflected a child welfare intent, and avoided labelling the child as delinquent.

In the years from 1967 through 1973, the proportion of admissions under Section 8 ranged from 42.5% to 46.3% (Birkenmayer & Polonoski, 1976, p. 3), still a very substantial minority of non-delinquents. Use of Section 8 declined sharply, however, starting in 1974, before the legislation to repeal Section 8 was enacted in 1975, and well before it became effective on January 1, 1977. This was a major factor in the drop in training schools admissions that is shown in Table 15.

Table 17

Legislation Under Which Training School Committals Were Ordered

	Training Schools Act				Juvenile Delinquents Act		Total No.
	Section 8		Section 9				
Year	No.	%	No.	%	No.	%	
1973	504	42.5	673	56.7	9	.8	1,186
1974	326	32.4	634	63.1	45	4.5	1,005
1975	139	16.1	608	70.2	119	13.7	866

Source: Birkenmayer & Polonoski, 1976, p. 3.

Boys were in the overwhelming majority in all juvenile correctional facilities throughout the period from 1950 to 1980, as shown in Table 18. However, Birkenmayer and Polonoski show that from 1967 through 1973, two-thirds to three-quarters of the girls who were sent to training schools were committed under Section 8, and from 1970 through 1975, girls constituted a majority of Section 8 committals. They note that on a year-to-year basis, girls accounted for a larger share of the decline in the use of Section 8 than boys did, and suggest that "the underlying cause in the declining use of Sec. 8 is a change in the societal norms regarding girls" (p. 27). Girls, whose share of training school first admissions had increased from 21% in 1950 to 30% in the 1970s, accounted for a far smaller proportion of new committals after repeal of Section 8 became effective, constituting less than 20% in 1980-81 when first admissions numbered only 613, and only 14% of the total of 570 in 1981-82.

Table 18

Sex of Children Served in Juvenile Correctional Facilities, 1950-80
(Per Cent)

Percent Male By Facility Type on Rolls, April 1	1950	1960	1970	1975	1980
Training Schools	79.0	72.5	70.7	69.6	81.6
Number =	(806)	(1,183)	(1,404)	(1,086)	(620)
Group Homes	-	-	-	71.1	80.0
Number =	-	-	-	(197)	(120)
Observation/Detention Homes	N.A.	N.A.	N.A.	67.5	N.A.
Number =				(160)(1)	

1. As of April 1, 1976.

Source: Annual reports of the Department of Reform Institutions for 1950-51 and 1960; the Department of Correctional Services for 1970-71; the Ministry of Correctional Services for 1975; Juvenile Information System data for 1980-81; Operational Review: Observation and Detention Homes (1977) by the Children's Services Division; the Child Advocacy Information System.

The average age of the children admitted to training schools rose steadily from 1950 on. Even before repeal of Section 8 limited eligibility to children aged 12 or older in 1977, the proportion of children aged 13 or older had risen from just under 80% to nearly 95%, as shown in Table 19.

Table 19

Age Distribution of Children Served in Juvenile Correctional Facilities
(Per Cent)

	1950-51	1960-61	1970-71	1975-76	1980-81
First Admissions to Training School During Year					
1. 7-12	20.6	15.0	10.1	5.5	2.4
2. 13-15	77.1	82.4	89.9	91.6	91.4
3. 16+	2.3	2.6	0	2.8	6.2
Number =	(576)	(1,110)	(1,450)(1)	(812)	(613)
First Admissions to Group Homes During Year					
1. 7-12	-	-	-	2.4	0
2. 13-15	-	-	-	70.3	66.2
3. 16+	-	-	-	27.3	33.8
Number =	-	-	-	(374)	(133)
Admissions to Observation/ Detention Homes During Year					
1. 7-11	N.A.	N.A.	N.A.	N.A.	2.1
2. 12-15	N.A.	N.A.	N.A.	N.A.	94.9
3. 16+	N.A.	N.A.	N.A.	N.A.	3.0
Number =	N.A.	N.A.	N.A.	(2,897)(2)	(4,247)(3)

1. This figure includes 22 children in residence in reception centres.

2. The figure of 2,897 admissions for 1976-77 is for detentions by judicial order, and was obtained from the report on the Ministry's 1977 operational review of observation and detention homes. The same report shows a far larger total served - 4,535 or 4,540 - which could incorporate usage of the homes as places of safety, or reflect total incidents of service as opposed to individual children.

3. This figure is for admissions by age from September 1980 through August 1981, and was obtained from the Child Advocacy Information System. Admissions figures for roughly the same period that were previously obtained from the Child Advocacy Information System were considerably lower: 3,405 for calendar 1980 and 3,817 for calendar 1981. However, the more recent the data in this new system, the more reliable the data are considered likely to be.

Source: See Table 18.

Illustrating the overlap between clienteles of the different service streams, Birkenmayer and Polonoski show (p. 8) that the proportion of all children admitted to training schools who had prior contact with a children's aid society rose from 13.4% in 1967 to 32.6% in 1973, and increased slightly in the next two years despite the decline in Section 8 committals.

The Residential Capacity of the Correctional System

The size of the training school system doubled between 1950 and 1972, the peak year, when the number of training schools reached 16 and their total capacity 1,731 beds (including Project D.A.R.E., an Outward Bound-style camping program). In that year, the Ministry of Correctional Services began to close training schools, a policy that would not have been possible without the existence of residential community alternatives to these facilities. This policy was continued when the training schools were transferred to the Ministry of Community and Social Services in 1977, with the result that the training school system as of March, 1980, numbered 7 schools with a total capacity of 521.

Correctional group homes, introduced by the Ministry of Correctional Services in 1972, totalled 40 with a capacity of 233 beds in 1975, but these numbers had declined by 1980, as shown in Table 20. "Expanded community programming," noted this Ministry's annual report for 1981-82, "has reduced the need to maintain group homes solely for training school wards. They are now used for a range of children with special needs, particularly those in the care of Children's Aid Societies".

The operational review of the observation and detention homes conducted by this Ministry following the transfer of responsibility from the Ministry of the Attorney General in 1977 found that 15 of the homes had been in operation in 1976. These homes were unevenly distributed across the province. Their capacity totalled 230 beds. All but one were used not only for juvenile delinquents awaiting court appearances but also as a "place of safety" for training school and children's aid society runaways and other children considered in need of protection. (The Toronto facility served only children charged with an offence.) The review credited the recent growth in number and total capacity of the homes to judicial initiative, particularly after the late 1960s. With the creation of additional observation and detention homes since the review, total capacity has grown slightly, while average size has dropped. Current Ministry policy places the homes within a four-level system providing home supervision, open detention, semi-secure detention and secure detention, primarily to serve young offenders, but also as places of safety. In 1980, as shown in Table 20, 27 homes with a total of 225 beds were in operation. The Ministry's 1981 policy statement on secure services indicated that an increase in semi-secure and secure capacity might be needed "if detention units are used as planned for pre-disposition assessment holding purposes" (7).

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7. Children's Services Division. Secure Services Paper: A Public Policy Statement. January 1981, p. 45.

Table 20

Number and Capacity of Juvenile Correctional Facilities

Facility Type	1950	1960	1970	1980
Training Schools(1)				
No. of facilities	6	9	13	7
Rated bed capacity, Mar. 1	845	993	1,498	521
Average no. beds/facility	140.8	110.3	115.2	74.4
Correctional Group Homes(2)				
No. of facilities	-	-	-	36
Rated bed capacity	-	-	-	212
Average no. beds/facility	-	-	-	5.9
Observation and Detention Homes(3)				
No. of facilities	3	6	9	27
Rated bed capacity	131	151	190	225
Average no. beds/facility	43.7	25.2	21.1	8.3
Total System				
No. of facilities	9	15	24	70
Rated bed capacity	976	1,144	1,688	958
Average no. beds/facility	108.4	76.7	76.7	13.7

Source: 1. Training schools data for the years from 1950 to 1970 were obtained from annual reports of the Department of Reform Institutions; for 1980 from 1979-80 Statistical Supplement of the Ministry of Community and Social Services.

2. Correctional group homes data for 1980 were obtained from Child Advocacy Information System data as of December 31, 1981. The homes were not in operation until 1972.

3. Observation and detention homes data for the years from 1950 to 1970 were obtained from Operational Review: Observation and Detention Homes (1977) by the Children's Services Division; for 1980 from Child Advocacy Information System data as of December 31, 1981.

Development of Community Services

In Ontario, the widespread questioning of the effectiveness of correctional programming was reflected in a research study, begun in 1969, that looked at factors in the rehabilitation of training school wards. Reporting in 1972, Lambert and Birkenmayer found that:

> outcome could not be explained or predicted in terms of the experiences boys or girls had in training school...No significant differences existed when the combined outcome ratings were examined in terms of the specialized treatment provided in training school or the wards' various behaviour patterns exhibited during the stay in training school...the child's subsequent community adjustment was not predicted by his training school assignment or experiences (pp. 15-16).

In 1966, in a departure from the traditional training school approach, the Department of Reform Institutions had established White Oaks Village, a training school with a treatment program for under-12-year-old (i.e., Section 8) boys in a cottage-style setting in Hagersville (Grant, 1982, p. 52). (Reclassified a children's mental health centre in 1977, White Oaks closed in 1982.) By the time the Lambert and Birkenmayer study was published, the department's successor, the Ministry of Correctional Services, had already implemented a number of program changes recommended by the study. Within training schools, increased emphasis was being given to life skills education. A special focus on the classification and treatment needs of the individual child was being provided at the reception and treatment centre in Oakville, opened in 1972. "A major step in the direction of meeting the needs of the more unstable wards in our care, by assigning them to small and personal units", the report noted, was the move by the Ministry of Correctional Services, begun in 1972, to open correctional group homes in community settings as therapeutic alternatives to training school.

The group homes were available only to children committed to a training school, and thus did not directly affect training school committals, but did have an impact on the time actually spent in training school (Review of Community Alternatives to Training School, 1981, p. 6). Partly as a result, the average length of stay in training schools decreased from 9 months in 1970 to 5-6 months in 1979-80 (Grant, op. cit., p. 58). In fact, Grant notes, "it was not unusual for newly committed wards to be transferred to one of these group homes, or to foster homes or other community group homes, after only a few weeks of assessment, and without ever being transferred into a regular training school program" (op. cit., p. 54). The increase in numbers of community placements of training school wards and the changing patterns of placement are shown in Table 21. It should be noted that the table shows numbers of placements, not individual children involved, indicating a higher turnover of places for fewer wards in recent years.

Table 21

Community Placements of Training School Wards
Per Cent

Type of Placement	1950-51	1955-56	1960-61	1965-66	1970-71	(2) 1975-76	1980-81
Own home	45.1	57.3	59.6	63.3	63.7	46.1	38.2
Foster/free/boarding/employed/special rates home	24.5	18.9	22.4	32.6	34.3	21.6	38.9
Self-contained accommodation	-	-	-	-	-	1.3	6.0
Position (farm, factory, domestic, etc.)	22.4	20.7	13.3	.1	-	-	-
Ministry group homes	-	-	-	-	-	23.3	6.9
Transfer to other institutions	8.0(1)	3.1	4.7	4.0	2.0	7.7	10.0
Number =	(789)	(890)	(1,349)	(1,774)	(2,214)	(2,012)	(2,045)

1. Data for 1950-51 may include transfers to other training schools.

2. Data for 1975-76 include placements from Ministry group homes.

Meanwhile, other developments increased the availability to the courts of community facilities as alternatives to training school committal.

With the development of private group homes following passage of the Children's Boarding Homes Act, juvenile court judges began to place adolescents directly in such homes in the 1960s, ordering municipalities to pay the costs. The practice became widespread in the 1970s. The numbers of children who have been placed directly in private group homes under the Juvenile Delinquents Act over the years is unknown. One study (Brubacher, 1977) found that from 1962 to the end of December 1976, judges sitting in juvenile courts in Metropolitan Toronto had made approximately a total of 1,300 orders, and the increasing numbers in recent years corresponded with a decline in training school committals from the area. A survey made by the Ministry of Community and Social Services in 1976 estimated that 1,300 such orders would be imposed on municipalities throughout the province in that year alone.

With municipalities protesting the costs, the Ministry agreed, beginning with the 1976-77 fiscal year, to cost-share municipal expenditures on these placements at a 50% rate pending legislation to replace the Juvenile Delinquents Act. Subsequent higher court decisions limited the ability of juvenile court judges to make the direct placements, and their numbers declined. While central statistics are not available for all of the years, municipal cost-sharing claims give some indication of the drop after the first of these rulings, the April 1977 Holland decision. In that month, approximately 340 children were on such placements, but in April 1979, only 60 children were listed by municipalities.

After the Holland decision, the Ministry encouraged the courts to make placements through children's aid societies. The societies were advised that their extra costs would be accepted and reimbursed through supplementary estimates. Again, the number of children who were subsequently diverted into the child welfare stream is not known. However, federal statistics on juvenile dispositions reported by the courts may provide some indication of the crossover. "Charge of Province" dispositions, which numbered 194 in 1975, increased to 441 in 1980(8).

In another significant development in 1974, the probation service that had been transferred from the Ministry of the Attorney General in 1972 was amalgamated with the aftercare service within the Ministry of Correctional Services, with the new Probation and Aftercare Officers providing a fuller service. Placements on probation, which had reached 4,518 in 1965, and had dropped to 4,172 in 1970, rose after the probation and aftercare service was created, reaching 5,214 in 1980, as shown in Table 23. With the age group served declining in numbers, the rate of placement on probation grew more sharply after the service was created, rising by 41.7% between 1970 and 1980.

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8. Ontario Statistics 1982, p. 238.

Table 22

Juvenile Probation
Per Cent

Year	No. of Children	Per Cent Change	Rate per 100,000 Children under 16	Per Cent Change
1950 (1)	1,474	-	119.2	-
1960 (1)	3,122	111.8	153.2	28.5
1970 (1)	4,172	33.6	176.9	15.5
1980-81 (2)	5,214	25.0	250.6	41.7

1. Children placed on probation/supervision during calendar year. Source: data for Ontario in Statistics Canada Catalogue No. 85-202, Juvenile Delinquency.

2. Children placed under probation/supervision from April 1 through March 31. Source: the Child Advocacy Information System.

A further indication of the courts' preference for alternatives to training school is an increase in the imposition of fines or restitution in the early 1970s. Although such dispositions had declined in the latter 1960s, their reported numbers grew from 755 in 1970 to 1,303 in 1975, an increase of 72.6%. While the number of such dispositions declined slightly to 1,296 to 1980, they constituted 13% of the smaller total number of delinquency dispositions in that year, compared with 10.2% in 1975(9).

Another recent community-based approach to the handling of young offenders that aims to reduce their penetration into the juvenile justice system is the use of formal diversion programs, whether at the pre-charge, the post-charge or the post-court stage. A clear outgrowth of the labelling theory, the concept of diversion originated in the late 1960s in the United States, where it was initially applied to adult offenders. Diversion projects in Ontario date from 1974, with the start-up of a program at Kingston. Most have involved contact with children after a charge is laid and before a court appearance. As of 1980, more than 40 such projects had been undertaken. The emphasis of individual projects has varied from restitution, reparation and community work by the young offender to a focus on the offender's perceived treatment needs (draft Ministry policy paper, September 1980, page A-4). If the juvenile fulfills the terms of an agreement, the charge he originally faced will be withdrawn or not laid.

Data on the number of children involved are not centrally collected. Thus the significance of diversion in terms of the total number of children served by the juvenile corrections system cannot be fully assessed. However, some idea of the scope of formal diversion can be gained from statistics of individual programs. In its first three years of operation starting June 1, 1977, 552 juveniles entered Project Intervention, the Essex County diversion program. In just under six months in 1980, 104 juveniles reached diversion agreements within the Waterloo Region program.

An attempt to summarize the available data on children served by the system has been made in Table 23. Not counting those involved in diversion projects, children served by juvenile corrections services (training schools, correctional group homes and probation and aftercare) in 1975-76 totalled at least 14,679 and in 1980-81 at least 15,307. Using these totals, the overall rate of service by the juvenile corrections system (training schools, correctional group homes and probation and aftercare) for 1975-76 was 643.9 and for 1980-81 was 735.6. However, the rate of service in training schools was lower in 1980 than in 1950, as shown in Table 23. The training schools rate declined by 22.4% over the period from 1950 to 1980, and dropped by 34.1% between the peak in 1970 and 1980.

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9. Statistics Canada Catalogue No. 85-202, Juvenile Delinquency.

Table 23

Children Served by the Juvenile Corrections System(1)

Service Type	1950-51	1960-61	1970-71	1975-76	1980-81
Training Schools					
On school rolls on April 1	806	1,183	1,404	1,086	620
New admissions during year	576	1,110	1,428	812	613
Re-admissions or returns(2)	202	440	745	1,140	849
Total served	1,594	2,733	3,577	3,038	2,082
Correctional Group Homes					
On group home rolls on April 1	-	-	-	197	120
First admissions to group homes during year	-	-	-	374	133
Probation and Aftercare					
Total served	N.A.	N.A.	N.A.	8,013 (3)	8,725 (4)
Observation and Detention Homes					
In residence on April 1	N.A.	N.A.	N.A.	160	N.A.
All admissions	N.A.	N.A.	N.A.	2,897 (5)	4,247 (5)
Total served	N.A.	N.A.	N.A.	3,057	N.A.
Rate per 100,000 Children under 16	129.0	134.2	151.7	133.3	100.0

1. Because the data shown here were gathered by different information systems it is likely that duplicate counting of children has occurred, i.e. one child may have been served by several parts of the system in a given year.

2. Returns from away without leave, hospital and leave of absence are excluded.

3. Total children served April 1 - March 31.
Source: 1975-76 annual report, Ministry of Correctional Services.

4. Total children served April 1 - March 31.
Source: Juvenile Information System.

5. The figure for 1975-76 is for detention by judicial order, and was obtained from the Ministry's operational review of observation and detention homes. The figure for 1980-81 is for admissions by age for September 1980 through August 1981, and was obtained from the Child Advocacy Information System. More recent information from the system is that admissions for 1981-82 totalled 4,656, and incidents of service 4,861.

Summary of Trends in Juvenile Corrections

Between 1950 and 1972, the training school system doubled its capacity to meet demand for residential correctional places. While numbers served by training schools grew even more rapidly for most of the period, rates of service in relation to the child population under 16 grew more slowly. Much of the demand was for service for children who were considered "unmanageable" in their home communities, and until 1965 could be admitted merely by administrative decision. Less than half of the children sent to training schools were children who had been adjudged delinquent in court.

During 1970s, questioning of the effectiveness of institutional programming, concern about the civil rights of juveniles and the development of community-based alternatives, both within and outside of the correctional system, reversed these trends.

- Direct community placements of juvenile delinquents increased.
- A decline in training school admissions began even before the system reached planned peak capacity.
- "Unmanageability" was eliminated as a reason for admission to training schools.
- As a result of training school closures, the combined capacity of training schools and the new correctional group homes was lower in 1980 than the capacity of training schools in 1950.
- The rate of service by training schools also was lower in 1980 than in 1950.

4. TRENDS IN MENTAL RETARDATION SERVICES

This chapter is divided into three sections. The first section of this chapter discusses historical influences on the rate of institutionalization of mentally retarded children for the period from 1950 to 1980, the period of institutional reform, the parents' movement and the impact of the availability of boarding homes. The second section describes the emergence of the Ministry's community services policy in 1973 and its implementation to 1980. The final section summarizes the various factors that contributed to the increase and decline in institutionalization of mentally retarded children between 1950 and 1980. The method used to develop data on children in mental retardation facilities is described in Appendix A.

The Trend Away from Institutions

In the years leading up to the period under consideration in this paper, services and programs for the mentally retarded were underfunded and overcrowded. Williston's classic report describes how the optimism about the potential for educating mentally retarded children that inspired the establishment in 1876 of Canada's first hospital training school for "feeble-minded" children, the Orillia Institution, gave way to a growing belief that it was futile to educate mentally retarded children. The early pioneers had set their sights too high in their belief that all retarded children could be taught to compete in society. By 1916, the training programs yielded to the goal of reducing the costs of operating institutions. For a short time between 1927 and the Depression, educational goals were re-introduced into Orillia. However, the near collapse of the economy, followed by World War II, resulted in reduced funding and overcrowding(10).

As part of its postwar program, the Government of Ontario began to establish new facilities to relieve the overcrowding and pent-up demand for residential care that had resulted from the limited government expenditures for mental retardation services. There were contradictory pressures in these years. While there was a growing demand for educational services for mentally retarded children so that they could be maintained at home, there was a simultaneous demand for an increase in the number of large institutions in the belief that the appropriate settings to provide care for mentally retarded people were institutional.

During most of the period from 1950 to 1980, a child in the care of a provincial institution who had a primary diagnosis of mental retardation usually, but not necessarily, lived in an institution designated for mentally retarded persons. A small proportion lived in institutions for the mentally ill.

In 1950, the Department of Health operated three facilities under the Mental Hospitals Act that were specifically designated as facilities for mentally retarded people. These were the Ontario Hospital School (in Orillia) and two Ontario Hospitals for the mentally retarded (in Cobourg and Aurora). The latter served adults and some children aged 15 to 19. There were also 13 Ontario Hospitals for the mentally ill.

As a result of both the establishment of new facilities and the conversion of psychiatric institutions for the mentally ill, the number of Schedule I facilities for mentally retarded people rose to 19 by 1976. With one subsequent closure and the transfer of another facility to a community board as a Schedule II facility for the profoundly mentally and physically handicapped, the number dropped to 17 by the end of 1977.

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10. Williston, 1971, pp. 21-29.

The number of children in mental retardation facilities grew from 1,425 in 1950, as shown in Table 24 below, to an estimated 4,235 in 1965, an increase of 197%. By 1980, this number had decreased to 2,004, a decline of nearly 53%. However, the rate of institutionalization in mental retardation facilities, which reflects population trends, grew from 95.4 per 100,000 children in 1950 to 154 per 100,000 children in 1965, an increase of 62%. In 1980, however, this rate was down to 73 per 100,000, a level lower than in 1950.

Table 24

Mentally Retarded Children (1) in Schedule I and II Mental Retardation Facilities and Homes for Special Care

	Residents In Schedule I & II Facilities		Rate Per 100,000	Residents in Schedule I & II plus H.S.C.	Rate Per 100,000	Per Cent Change
1950	1,425	(2)	95.4	1,425	95.4	-
1955	2,161	(2)	114.1	2,161	114.1	+19.6
1960	3,087	(2)	130.7	3,087	130.7	+14.5
1965	4,235	(est.)	154.3	4,235	154.3	+18.1
1970	3,232	(est.)	111.1	3,525	121.2	-21.5
1975	2,330	(est.)	80.2	2,711	93.4	-22.9
1980	2,004	(actual)	73.0	2,247	81.9	-12.3

1. Children aged 0-19 years.
2. Schedule I facilities only.

Source: See Tables 45 and 46 and 47 in Appendix A.

When mentally retarded children in homes for special care (considered more handicapped than those in Schedule I and II facilities) are added to the children in mental retardation facilities, the rate for 1980 is 82 per 100,000, also lower than in 1950.

Under the postwar provincial expansion program, the first wing of the staged construction of a new Ontario Hospital School at Smiths Falls was opened in 1951 with 373 adults and 173 children, and plans were under way for an exact replica in Cedar Springs. (At its peak, on December 31, 1963, Smiths Falls would have 300 adults and 1,581 children in residence; another 664 persons would be on leave of absence.) Meanwhile, 2,500 children under age 16 were waiting for admission to the Ontario Hospital School in Orillia, and new residential facilities for 200-300 children were under construction on the grounds of the institution. There was on average 22.4% overcrowding in Ontario's institutions(11).

By 1960, conditions were so overcrowded that "admissions at all institutions were invariably arranged through Members of the Legislature"(12). Superintendents were told, not asked, which persons would be admitted. There were no pre-admission visits. Orillia, with 1,560 children (aged 0-19) and 949 adults in residence, and Smiths Falls, with 1,326 children and 494 adults, were bursting at the seams. Operating expenditures for institutions were so constrained that in 1970 "there were few, if any, toys in the wards, and the patients' clothing tended to have a very institutional appearance"(13).

Meanwhile, the parents of mentally retarded children began to develop an important service and advocacy movement. Public education had been available since 1914 only to children with IQ's of 50 or more. The Parents' Council for Retarded Children was organized in Toronto in 1948, its primary aim to urge the Department of Education to make facilities available for the education of children with IQ's of less than 50. The Parents' Council began to operate classes for a few children with IQ's of less than 50 in several locations in Toronto. By 1953, the Ontario Association for Retarded Children was operating in seven cities. In that year, the Education Act was revised to permit the payment of $250 per pupil per year for children attending classes operated by local associations for the mentally retarded. Eleven parent-operated schools for mentally retarded children with an enrollment of 250 pupils received grants in 1953. By 1960, schools operated by local associations for the mentally retarded served 1,949 children and received $657,000(14) in provincial grants.

Although Williston describes the 1950s as marking a renaissance in the field of mental retardation, it is evident that there was divergent thinking about the care and treatment of mentally retarded persons. Simmons points out that both the Government and the public, including the Ontario Association for Retarded Children, continued to believe that the best place to care for mentally retarded people was in a hospital or nursing home setting. Simmons cites a 1960 brief to the Ontario Cabinet by the Ontario Association for Retarded Children urging the Government to build two 1,200-bed institutions immediately and three more by the year 1966(15).

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11. Ontario Department of Health. Report of the Ontario Health Survey Committee, 1952, p. 110.

12. Williston, op. cit., p. 30.

13. Ibid, p. 29.

14. Department of Education annual report for 1960.

15. Simmons, in press, 1982.

Williston refers to 1964 as the turning point in mental retardation services(16). As a result of the Federal-Provincial Conference on Mental Retardation held in 1964, Dr. M.B. Dymond, Minister of Health presented to the Legislature on June 7, 1965 a planning document known as the "Blueprint" that outlined a plan for institutional reform and a change in emphasis from institutional to community care. In 1966, the Mental Retardation Services Branch was established to implement its recommendations.

The provincial goal was to move residents whenever possible from institutional to community care. Within institutions, programs were restructured from the hospital model of care to the training focus of a century earlier. Individualized programs were encouraged, and staff development to strengthen the capabilities of staff to implement these programs became a major priority. Nursing care for profoundly and severely mentally retarded people was transferred from the Hospital Schools to private infant nursing homes (identified in the tables as Schedule II facilities) and homes for special care, to enable them to receive nursing care while remaining close to their families.

Two major effects of the implementation of the Blueprint were the depopulation of the largest institutions and the development of expertise within institutions in the areas of assessment, diagnosis, individual program planning and training of the highest to the lowest functioning persons. Many of the program approaches pioneered in the facilities have been transferred successfully into accommodation and training programs in the community. Specialized facilities, such as Surrey Place Centre in Toronto and Children's Psychiatric Research Institute in London, developed infant stimulation, behavior management, short-term parent relief and family support services. After 1975, these became the major services to be developed in the community.

The depopulation of the largest facilities between 1965 and 1975 was accomplished primarily by transferring residents, particularly adults, into homes for special care and by controlling the number of admissions. Under a program that had been introduced in 1965 by the Department of Health in response to public pressure to alleviate overcrowding in psychiatric institutions, large numbers of residents were discharged from the psychiatric facilities into two types of homes for special care: residential homes and nursing homes. In 1968, the homes for special care legislation was changed to permit the Government's mental retardation facilities to discharge residents into these homes. Table 25 shows the extent of the depopulation trend in the three largest institutions that began in 1965.

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16. Williston, op. cit., p. 30.

Table 25

Children and Adults on Books of Ontario's Three Largest Mental Retardation Facilities

	Orillia	Smiths Falls	Cedar Springs	Total	Per Cent Change
1965	2,874	2,564	1,054	6,492	-
1970	2,327	2,154	1,032	5,513	-15.1
1975	1,532	1,499	923	3,954	-28.3
1980	999	1,102	677	2,778	-29.7
1982	954	1,035	660	2,649	-4.6

Source: Annual reports of the Mental Health Branch, Department of Health (1965); Mental Health Division, Department of Health (1970 and 1972); Statistical Summary, Schedule I and II Facilities for the Mentally Retarded, M.R. Facility Services Division, Ministry of Community and Social Services (1980); Population Statistics, Facilities for the Retarded, Institutional Services Unit, Ministry of Community and Social Services (1982).

The majority of children in homes for special care today live in nursing homes. (In 1977, there were 226 children, aged 18 and under, in nine nursing homes and four children in residential care under the Homes for Special Care Program.) The nursing homes have a bed capacity ranging between 29 and 80 beds, and are usually 100% occupied. Many of the children have such severe multiple handicaps that they are restrained in cribs or cages for their personal protection. The Ministry concluded in 1978 that the children as a group are more handicapped than children in Schedule I and II facilities. The care the children then received served only basic survival and medical needs. There was no provision in terms of space and personnel for developmental programming. This situation continued until March 1980, when the Ministries of Community and Social Services, Health, and Education jointly undertook an assessment and training program for mentally retarded persons in the Province's nursing and residential homes for special care. Under this initiative, the residents in these facilities began to receive multidisciplinary assessments followed by case conferences and funding for infant stimulation, early childhood education, behavior management and pre-vocational training programs. Thus children in homes for special care for the first time had access to developmental programming as did those in Schedule I and II facilities.

The primary residential alternative after 1965 to large institutions for children appears to have been the service provided by children's aid societies. The Williston report stated that 18.7% of children in the care of the Metropolitan Toronto Children's Aid Society in 1971 were mentally retarded(7), and estimated that as many as 30% of children under society care were mentally retarded(8).

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7. Williston, 1971, p. 51.
8. Ibid, p. 2.

How many mentally retarded children under society care were placed in children's boarding homes, in society-operated group homes and in foster homes is unknown. Foster care has probably been a relatively minor program for the care of mentally retarded children. A survey carried out by the Ontario Association of Children's Aid Societies in the 1960s indicated that 4.6% of children in foster care were mentally retarded (and 6.5% were disturbed)(19).

The 1965-66 annual report of the Department of Public Welfare made specific reference to mentally retarded children in facilities under the Children's Boarding Homes Act. "A number are seriously retarded mentally and will eventually be admitted to Ontario Hospitals. In the meantime the children's boarding homes are meeting an urgent need" (p. 4). Evidently, children's boarding homes were at the time considered temporary shelters for children who would eventually be placed in institutions. However, a 1973 policy paper stated that many of these homes served retarded children specifically(20), and the Ministry's annual report for 1978-79 referred to these homes as providing "residential programs for disturbed and developmentally handicapped children" (p. 11). Ministry records show that there were 26 children's boarding homes with a capacity of 318 serving mentally retarded children in July 1978.

The year 1965 was also significant for the public education of children with IQ's of less than 50. Parent-operated schools for these children were transferred to local educational authorities. Then, in 1967, all local boards were required under the amended Secondary Schools Act to provide educational services to "trainable mentally retarded" children. Indicative of the effect of this legislation are the statistics in Table 26.

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19. Dymond, 1974, p. 13.

20. Welch, 1973, p. 36.

Table 26

The Impact of Educational Services for Trainable Mentally Retarded Children

Year	Children Attending Schools for the Trainable Mentally Retarded	Children in Schedule I & II Facilities	Total
1953	250 (1)	1,770	2,020
1955	900 (1)	2,161	3,061
1960	1,949 (1)	3,087	5,036
1965	3,364 (1)	4,235	7,599
1970	N.A. (2)	3,232	-
1975	6,882 (2)	2,330	9,212
1980	7,264 (2)	2,004	9,268

1. Attending parent-operated schools.

2. Attending local school board-operated schools.

Source: Annual reports of the Minister of Education for 1953, 1955, 1960 and 1965; enrollment in schools for the trainable mentally retarded, Ministry of Education, Management Information Branch, April 1981.

Between 1953 and 1965, there was a more than 12-fold increase in the number of children, presumably with IQ's of less than 50, attending parent-operated schools for the trainable retarded. The number of mentally retarded children in Schedule I and II facilities increased by a factor of 1.4. Subsequently, between 1965 and 1980, the number of children in the schools for the trainable mentally retarded increased by 116% while the number of children resident in the institutions decreased by 53%. The availability since 1965 of public education for children with lower IQ's coincides with the decline in the rate of institutionalization of mentally retarded children from 154 to 73 per 100,000 (82 per 100,000 if children in homes for special care are included).

The Community Services Policy

While 1965 was a turning point in the rate of institutionalization, it was not until 1973 that a new policy focus on community alternatives to institutionalization of mentally retarded children received serious consideration. The paper setting out the new policy stated that "The principal focus of policy planning for the mentally retarded must be the provision of services in a community setting as a primary alternative to institutionalization...Wherever possible, a mentally retarded child should be cared for within a family setting"(21).

In this paper, the Provincial Secretary for Social Development, the Hon. Robert Welch, summarized the incentives that existed at the time towards placement of a mentally retarded person in an institution(22). Among the incentives was an absence of costs to families, children's aid societies and charitable corporations when a mentally retarded child was placed in an institution. On the other hand,

- Full costs were incurred by societies for placing a child in a community setting.
- Families of retarded persons or charitable corporations had to contribute 20% of the operating costs of community residences.
- Education could be denied to school-age mentally retarded children who could not benefit from the programs established by the local board, leaving these children without daytime activity programs.

Following the Government's articulation of the community living policy, the Ministry of Community and Social Services became responsible in 1974 for developing a full range of community services for the mentally retarded. The mental retardation institutions that formerly reported to or were operated by the Ministry of Health became responsible to the Ministry of Community and Social Services. The Ministry of Health's Mental Retardation Services Branch was also transferred to this Ministry. The community services programs implemented in recent years are described below.

Residential Community Programs

Recently, about 360 mentally retarded children have been admitted each year into long-term care in residential programs funded by the Ministry through the Homes for Retarded Persons Act or the Developmental Services Act(23). Prior to 1975, group residential care for these children almost always meant institutional care. In 1975, the Ministry initiated a five-year implementation plan containing detailed proposals for the development of community residential alternatives as well as work, training and support services. Most of the Ministry's expenditures for children's services were devoted to community support services designed to help maintain the child in his or her family setting. However, some efforts were also directed at community residential alternatives for children who could not be maintained in their family settings. Table 27 summarizes the development of these residential services since 1965.

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21. Welch, 1973, p. 22.

22. Ibid, pp. 7,9.

23. Community Residential Services for the Developmentally Handicapped, p. 17.

Table 27

Community Residential Programs for Mentally Retarded Children

	No. of Group Homes	No. of Children
1965	3	101
1970	3	101
1975	8	194
1980	16	267

Source: Developmental Services Unit, Operational Support Branch, Ministry of Community and Social Services.

The major focus of community residential programs for mentally retarded children since 1975 has been to develop models of community care for children with more severe handicaps and needs. In 1975, all but one of the homes provided care for children in the mild to moderate range of mental retardation. Most of the new programs that were established subsequently were for severely to profoundly mentally retarded children, and two programs included multiply handicapped children. The latter types of residences initially received full subsidy for capital and operating expenditures.

Non-Residential Community Support Programs

A variety of children's programs have been developed since 1976 under the Developmental Services Act to maintain the child in his or her own community and to reduce the likelihood that residential placement will be sought. These non-residential community support programs are the most significant developments during the entire period under discussion.

The various community support programs can be classified into the following categories:

- general community support
- developmental day care
- the handicapped children's allowance.

1. The general community support programs include:

   - Family support workers: A large number of local associations for the mentally retarded and generic agencies receive funding for workers who serve families with a mentally retarded child by arranging access to needed resources in the community.

- Infant stimulation: Trained workers from the behavioral and rehabilitation disciplines visit homes, receive clients in centres, or use both approaches to assist parents of mentally retarded infants up to two, by providing early intervention and stimulation to the infants.

- Behavior management: Workers with a behavior modification background visit families, see clients within centres, or use both approaches to strengthen desirable behaviors and weaken maladaptive behaviors of children and adults.

- Recreation development projects: Several projects have been funded to help municipal recreation departments develop special and integrated programs for retarded children and adults.

- Communication: Programs using a mediator model of communication training have been funded since 1976. The programs teach parents how to stimulate and elicit communicative behavior from non-verbal or marginally verbal children.

- Toy libraries: A number of agencies have received funds to establish and operate a toy lending library to provide mentally retarded children with a wide range of play opportunities.

- Diagnostic and assessment services: Diagnostic and assessment services were developed within the mental retardation facilities and children's mental health centres in the 1970s. Funding has been available since 1974 under the Developmental Services Act to establish multidisciplinary assessment teams outside of institutional settings.

- Parent relief/respite care: Parent relief is considered one of the most important community support programs. These programs provide short-term respite care in the child's home or in a residential setting in response to emergencies, daily living stresses and vacation needs. Care is provided by host families, homemakers, drop-in centres and babysitters. Within residential settings, certain beds have been allocated to provide relief to families. As of October 1982, there were 122 short-term respite care beds under the Homes for Retarded Persons Act. It is estimated that each bed can serve 13 clients per year, for a total of 1,586 clients annually.

In 1980, 152 such projects were funded, serving 14,658 children, as shown in Table 28.

Table 28

General Community Support Projects Funded in 1980

Category	Number of Projects Funded	Number of Children Served
Family Support Workers	39	2,496
Infant Stimulation	32	1,590
Parent Relief	32	5,824
Behavior Management	17	1,139
Communication	8	557
Assessment	2	254
Other	22	2,798
Total	152	14,658

Source: Developmental Services Unit, Operation Support Branch, and Handicapped Persons Unit, Policy Development Branch, Ministry of Community and Social Services

2. Developmental Day Care: Prior to passage in 1981 of special education legislation amending the Education Act, there was no obligation for community school boards to provide training and education to severely and profoundly retarded children. In 1971, the Ministry began to fund developmental day nurseries providing substitute activity programs for children up to 18 years. Table 29 indicates the growth of services for this group.

Table 29

Developmental Day Care Centres

Year	No. of Centres
1973	9
1974	10
1975	15
1980	61

Source: Annual reports of the Ministry of Community and Social Services.

In 1981, 1,287 developmentally handicapped children were served in specialized developmental centres, of whom 392 were of school age; 178 other developmentally handicapped children attended integrated centres. (Under the special education legislation, responsibility for services for the six-to-18 age group will be transferred from the Ministry of Community and Social Services to the Ministry of Education by 1985.)

3. The Handicapped Children's Allowance: In June 1977, the Handicapped Children's Allowance program was introduced. The program is designed to encourage families to care for their handicapped children at home, where possible, by assisting them with the additional costs resulting from the child's disability. In 1977, the program provided families an allowance of up to $150 per month. In 1980, the maximum was increased to $175 per month. Table 30 indicates that this program grew quickly in a short time.

Table 30

Recipients of the Handicapped Children's Allowance

	Max. Available Per Month	No. of Recipients
1977	150	738
1979	150	1,102
1980	175	2,169

Source: Annual reports of the Ministry of Community and Social Services.

(In 1982, the maximum was increased to $225 per month.)

Summary of Trends in Mental Retardation Services

During the first half of the period under consideration, the major option for parents who hoped for some relief from concern about the futures of their retarded children, especially those not judged educable within the meaning of the Education Act, was to seek admission to an Ontario Hospital School. On admission of the children, some parents lost all contact with them.

The demand for institutionalization might have been much stronger had it not been for the parents' movement. Beginning with a few classes in the early 1950s, parents organized and operated, with government support, education services for 3,364 of their children by 1965. Even with these efforts, there were more children in institutions than in the parent-operated schools.

Since 1965, changing attitudes about the appropriate means of care for mentally retarded children have been reinforced by the growing availability of alternatives to institutions. It seems significant that the decrease in the rate of institutionalized mentally retarded children after 1965 coincided with the expansion of schools for "trainable" mentally retarded children and children's boarding home places. While there were 1.3 times as many children in institutions as in schools for trainable mentally retarded children in 1965, by 1980 there were over three times as many children in these schools as in institutions. Community support services, developmental day care and the handicapped children's allowance have also helped reduce institutionalization. Community residential alternatives under the Homes for Retarded Persons Act and the Developmental Services Act have also played a significant role.

5. THE CHILDREN'S MENTAL HEALTH SYSTEM

This chapter reviews the development of children's mental health services in Ontario. The opening section describes the background to the development of present services, the first residential treatment programs and the rapid expansion of mental health services for children in the 1970s. Later sections describe the development first of treatment programs in family-style settings and then of alternatives to residential treatment. The concluding section discusses cross-service stream impacts of significance for the children's mental health system.

A Public Health Approach

Specific services to diagnose and treat mental illness in children did not appear in Ontario until the third decade of the 20th century. This was a significant lag behind the development of services to meet children's other special needs, for example, the founding of children's aid societies as a result of the Children's Protection Act of 1893 and the establishment of the "asylum" at Orillia in 1876 for the training of mentally retarded children.

In 1914, a Social Service Clinic was established at the Toronto General Hospital to provide psychiatric consultation to schools, the children's aid society and the juvenile court. Apparently, however, it was largely preoccupied with what was viewed as the "problem" of retarded children, and was popularly referred to as "The Feeble-Minded Clinic"(Griffin & Greenland, 1977, p. 22). In the 1920s, the Toronto Department of Health opened a clinic providing psychiatric consultation to schools. This was followed, in 1930, by the Province's establishment of six travelling mental health clinics, each based in a provincial mental hospital. From the beginning the majority of cases referred to these clinics were children. In 1931, 85% of the people seen were under the age of 21, with about one-third having been referred because of suspected or actual mental retardation. These clinics continued, but with little expansion, until after World War II, even though as early as 1936 concern was expressed about the clinics' ability to handle increasing demands for their services (Henderson, 1977, pp. 116-117). Also in the 1930s, the Toronto Psychiatric Outpatient Clinic began to offer services to children on a regular basis. A "mental consultation service" began in what is now the Borough of York in 1936, and subsequently became a full-time outpatient clinic specifically for children and adults. In 1937, a "Clinic for Psychological Medicine" was established at the Hospital for Sick Children (Griffin & Greenland, op. cit., p. 23).

All development of mental health services for children ground to a halt during World War II. However, in 1944 a "mental hygiene consultation service" was established in Toronto to provide consultation to social workers serving children with emotional disturbance. In 1946, the Ontario Government expanded its mental health clinic services by appointing consultants to operate out of general hospitals in some of the centres with larger populations and to develop community mental health programs. For many years, children under the age of 16 made up 42% to 44% of the total caseload of these services(Henderson, op. cit., p. 117). In 1948, federal grants made additional funds available, and a number of boards of health took advantage of them to establish specific "child guidance clinics". The concept underlying the development of these clinics and child guidance centres was a public health approach. At the same time, the Province began making grants to general hospitals for the construction of psychiatric units to decrease the emphasis placed on large provincial mental hospitals. While these general hospital units were used primarily by adults, they did provide some diagnostic services and short-term inpatient services to children.

In summary, at the end of the 1940s, Ontario had a beginning network of outpatient mental health clinics serving both adults and children and a few child guidance centres. There was no specific residential treatment centre for children, and those requiring this service had to be admitted to programs for adults in either general or mental hospitals.

The First Residential Treatment Programs

A number of residences that originally had been established to provide care for orphans, such as Sunnyside Children's Centre in Kingston and the Protestant Children's Village in Ottawa, began in the early 1950s, to get funds from the Department of Public Welfare to develop treatment programs for "multiplacement children". These were generally youngsters in the care of a children's aid society who had been through a variety of foster homes and whose behavior was considered unacceptable by such settings. The development of these treatment programs paralleled a growing recognition that the traditional public health approach had limited application. This trend was formally recognized in the 1963 Children's Institutions Act, where Schedule III and IV facilities were classified according to the degree of "disturbance" presented by the children in them. In 1965, the then Minister of Public Welfare, the Hon. Louis Cecile, commented on the fact that several of the facilities governed by the Children's Institutions Act showed "signs of a changing and deepening therapeutic orientation"(22), and specifically noted that two of nine facilities designated for "normal" youth would be converted to residences for "mild disturbed", and five of 12 for "mild disturbed" would be converted for use with "disturbed".

One of these "welfare" children's residences, and a pioneer in consciously developing a treatment orientation, was Warrendale, established in 1952 by the Board of St. Faith's Lodge. Appointed director in 1953, John Brown brought with him Fritz Redl's ideas of the importance of the child's daily living experience and the need to treat behavior in its natural context. By 1954, Brown was implementing these ideas by, contrary to orthodox child care work practice at the time, grouping children and staff for heterogeneity of age, sex and needs. He established "family" units within the larger centre by assigning permanent staff to each unit who were instructed to form a parent/child type of relationship in the context of normal, predictable daily routines (Brown, 1977, pp. 97-103). However, the program in total continued to operate out of a large mansion with 20 or more children at a time. In 1965, part of the centre moved to Warrendale Court, a group of four ordinary-sized houses on an ordinary-looking street in Rexdale(23). It thereby obtained physical facilities compatible with its family approach and stress on the preparation of the child for normal life in the community. However, in this first attempt at community-based treatment, the houses were clustered together on a cul-de-sac rather than, as later, scattered over a larger geographical area. As a result, a relatively large number of emotionally disturbed children continued to be in close proximity to each other even though living in separate houses.

Meanwhile, in 1957, the Ontario Government had purchased the Hospital for Sick Children's Thistletown campus, in what was at that time a rural area, to establish the first mental hospital specifically for children. Initially, it offered only residential services, and its outpatient facility was not constructed until 1965. In 1957, Thistletown was very much a hospital in the orthodox mold, divided into wards with high ceilings and tile floors. Some attempts were made through decorating to soften the environment, but by virtue of size (64 beds) and design it retained an institutional feel until 1972, when the children and adolescents moved into cottages built on the grounds.

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22. 1965 submission to the Ontario Legislative Assembly Select Committee on Youth, p. 58.
23. Browndale Information Resource Manual, 1980.

In 1967, the Toronto Mental Health Clinic, which had been seeing both adults and children on an outpatient basis, became the Hincks Treatment Centre for Children and Adolescents with the opening of a new building on Jarvis Street. It now had facilities to offer both inpatient and outpatient services. Though considerably smaller than Thistletown and not located in a rural area, it was not an ordinary house in an ordinary residential neighbourhood.

Rapid Expansion of Services

In 1967, the Province had a range of outpatient mental health clinics serving adults and children, a few children's residences (mostly in fairly large buildings) providing treatment to children perceived as emotionally disturbed and a couple of large children's mental hospitals (Thistletown and the Children's Psychiatric Research Institute). In addition, inpatient and outpatient services could be obtained through adult programs in general hospitals and Provincial Mental Hospitals. However,

- The demands for services for emotionally disturbed children exceeded the available resources.
- The distribution of services across the province was uneven (being concentrated mainly in the south central and southwest portions).
- The majority of services were for six to 12-year-olds, and there was little service provision for emotionally disturbed preschoolers or adolescents.
- Most residential services were financed in part by the Government or the United Appeal but mainly through the user. In practice, this meant that a disproportionate number of children's aid society wards were in treatment placements to the exclusion of non-ward children because per diem rates had become a deterrent for most ordinary families.

The Select Committee on Youth, reporting in 1967, noted that treatment centres were in short supply, and that "many children are thus being sent to inappropriate institutions such as training schools, children's aid group homes and charitable institutions for the homeless, when in reality they require special treatment" (Select Committee on Youth Report, 1967, pp. 380-381).

The committee recommended that the Province:

- make available mental health diagnostic and treatment services to all communities not having them
- provide regionally located residential diagnostic and treatment services for emotionaly disturbed children
- fund the above facilities.

The Government had been concerned about the lack of services for emotionally disturbed children and youth, and for nearly a year the five departments serving this age group (Education, Health, Welfare, Reform Institutions and Attorney General) had been studying the issues. As a result, on January 27, 1967 the then Minister of Health the Hon. M.B. Dymond, tabled a "white paper on Children's Facilities for Mental and Emotional Disorders" that proposed:

- the establishment, by the Department of Health, of regional centres that would provide: diagnosis; inpatient, outpatient and day treatment, and be the focal point for coordination of services in a geographic area; staff training; program evaluation and research; and

- the development of legislation that would:
  - delineate basic standards for the establishment and operation of treatment centres for children and adolescents
  - provide the Department of Health with the power to license and to revoke a licence to operate from a program if standards were not met
  - render centres listed in legislation eligible to receive 100% of approved operating funding (which would eliminate any financial burden for parents seeking residential treatment for their children).

The first step to implement these recommendations was taken in 1967 with the designation of regional centres at Ottawa, Kingston, Toronto, Hamilton, London, Windsor, Sudbury and Thunder Bay.

The acceptance of the 1967 white paper marked the beginning of the development in Ontario of legislatively designated treatment centres for emotionally disturbed children and youth. As already indicated, in actuality, such programs had been offered through some facilities under the Children's Institutions Act and by specifically established programs such as Thistletown and Hincks. In 1968, the federal Department of National Health and Welfare identified 12 residential treatment centres, two children's mental hospitals and six units in provincial mental hospitals in Ontario for emotionally disturbed youngsters (Osborne, 1968.)

In 1969, the Department of Health set up the Children's Services Branch, under Dr. Naomi Rae-Grant, a child psychiatrist with extensive U.S. experience. This provided, for the first time in Ontario, a locus for the establishment of children's mental health service delivery system objectives and coordination of what was a scatter of isolated and unrelated services of varying levels of efficiency and effectiveness. For the first year and a half, the work of the Branch consisted of developing and preparing what was to be the Children's Mental Health Centres Act (Bill 138), and visiting all programs claiming to provide treatment in order to get a feel for the range and quality of existing services.

The Children's Mental Health Centres Act received formal assent on December 17, 1969. It placed the authority for the inspection, licensing, supervision, and funding of all special treatment facilities for emotionally disturbed children and youth under Health. When this Act was implemented on April 1, 1971, 20 residential facilities, with a total of 615 beds, and nine non-residential facilities were designated as being under its jurisdiction(24).

At that time, the Ministry of Health also identified what it considered to be the top priorities to be addressed in the children's mental health services field. These included:

- programme enrichment and expansion in existing facilities for children and youth with a new focus on community-based services and a new emphasis on non-residential out-patient programmes, day-care and follow-up designed to keep children and families together;
- a gradual shift from long term hospital-based programmes, except for those youngsters whose medical-psychiatric needs require such facilities;

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24. Children's Mental Health Services, Provincial Overview 1971-1976, Children's Mental Health Services Branch, 1977.

- the whole question of prevention in terms of earlier identification of social-economic stress and earlier intervention in terms of innovative methods of service delivery carefully researched and appropriately provided; and
- the eventual development of standards and guidelines for good quality care and treatment of troubled youngsters. (Facts, Figures and Forecasts, Children's Mental Health Services Branch, 1974, italics added)

In 1971-72, the children's mental health system could provide residential service for 880 children and youth at any one time through:

- 615 beds in 20 licensed children's mental health centres
- 103 beds in special units in six psychiatric hospitals
- 162 beds in regional centres(25).

While committed to the concept of emphasizing non-residential care, the Government also felt an obligation to address:

- geographic inequities resulting from the fact that most services were in the south central and southwestern parts of the province
- the shortage of services for adolescents, and
- the lack of services for francophones, who at the time were sent to Quebec for residential treatment.

Between 1972 and 1974, therefore, the Government deliberately fostered the development of:

- six new children's mental health centres for adolescents
- an expansion of 32 beds at Thistletown for adolescents
- a residential unit in both the Ottawa-Carleton and the Royal Ottawa Hospitals, the latter with a bilingual component.

It also approved expansion of the residential capacity of the Sudbury-Algoma Sanatorium. This brought the residential capacity for children and youth to 1,322 in 1973-74.

The same process was repeated over the next two years with the establishment of:

- new child and adolescent units at the Kingston Psychiatric Hospital, the North Bay Psychiatric Hospital and the Lakehead Psychiatric Hospital in Thunder Bay
- a children's mental health centre in Ottawa
- a group of houses operated by Browndale (a new program started by John Brown after he left Warrendale) in Thunder Bay(25).

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25. Children's Mental Health Services, Provincial Overview, 1971-1976, op. cit.

It should be noted that the above rapid expansion of residential services resulted from a conscious decision to fill in gaps, and took place concurrently with the encouragement of the development of non-residential services (as discussed in a later section).

The expansion of residential services reached its peak about 1975, as demonstrated in Table 31. After that time, centres (especially in the south central and southwestern parts of the province) were encouraged to divert some of their resources from residential to non-residential services, and new programs were encouraged to emphasize non-residential treatment. Following the transfer of responsibility for children's mental health centres to the Ministry of Community and Social Services, after formation of the Children's Services Division in 1977, further development of non-residential treatment continued to be emphasized in provincial policy.

Table 31

Residential Treatment Capacity and Numbers of Children Served

	No. of Licensed Beds(1)	No. of Children Served(2)
1970		1,733
1972	880	
1974	1,322	
1975		12,511
1977	1,304	
1980		13,711
1981	1,036(3)	

1. Does not include the number of actual "set-up" (operational) beds, which tends to be lower than the number of licensed beds; also does not include units in general hospitals.

2. Includes units in general hospitals (which are not included in the number of licensed beds in column 1).

3. Does not include beds in psychiatric hospitals, which are included in the statistics for 1972 and 1977, and is an estimate only.

Source: Column 1 - "Changes in the Cost and Extent of Services in Children's Mental Health Centres, 1972-1977", Children's Mental Health Services Branch, 1977

- "Children's Mental Health Centre Programs and Financial Review", Funding and Evaluation Branch, Ministry of Community and Social Services, 1981.

Column 2 - Psychiatric Hospitals Branch, Ministry of Health for 1970, Children's Mental Health Services Information System (CMHSIS).

At the same time, the length of stay in residential care fell sharply. In the latter 1960s, the length of stay ranged from two to four years (McConville, 1977, p. 130). At Thistletown in 1976, the average length of stay was 10 months (Shamsie, 1977, p. 55). In 1980-81, stays in residential care averaged 9.2 months(27).

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27. CMHSIS, July 2, 1981.

Ordinary Houses on Ordinary Streets

Prior to 1968, treatment programs in Ontario, even if located in the community as opposed to a hospital, tended to operate in large hospital or school-like buildings, many of which had previously been orphanages. The move in 1965 of Warrendale to a cul-de-sac in Rexdale was a start towards ordinary houses on ordinary streets, but the houses were clustered together rather than being scattered throughout a residential area. In 1966, Browndale opened a number of treatment houses in Haliburton and around Newmarket with groups of four to five boys and girls of mixed ages (Levine & Jackson, 1977). While these were definitely non-institutional in size, and were not clustered together, they were in a rural setting although they served primarily urban children. This resulted in some youngsters, by virtue of distance, being cut off from the families and communities to which they belonged. The rural setting was also not the best for training the skills needed to cope with city life.

In 1967, Browndale began opening houses for five and six children each scattered throughout Peel and Scarborough. The size of the house, and the fact that the child lived in a group of boys and girls of mixed ages and participated in household chores and community activities, contributed to a home-like atmosphere(28). However, the children tended to be segregated in a Browndale school, in part as a deliberate treatment strategy and in part due to difficulty in getting suitable classroom placements in local schools. In 1970, the Peel and Scarborough houses were closed as the result of a long battle with local authorities over zoning.

Meanwhile Youthdale, a Toronto-based centre, established its first "treatment home" in an ordinary house in a downtown residential area to serve Toronto children. This was soon followed by others(29). Youthdale managed to get some of its youngsters admitted to local schools while providing others, whose treatment appeared to require it, an academic program in the Youthdale school.

Youthdale, like Browndale, fought ongoing battles with local municipal officials who viewed the houses as contravening zoning by-laws, and attempted to close them. Unlike Browndale, Youthdale managed to keep functioning until, in a precedent-setting judgement in 1973, Mr. Justice Lacourciere of the Court of Appeal in Barrie decided that a Browndale "treatment home" was more like an ordinary family home than an institution, and could legally be located in a community.

Once the Barrie court precedent was accepted by municipalities, though often reluctantly, the move into ordinary houses in residential neighbourhoods spread. Not only did Browndale open treatment homes in other communities, but existing programs, such as Huntley Youth Services and Sacred Heart Village, located some of their programs in ordinary houses. The whole children's mental health field adopted the idea that if a child had to be in residence it should be in a small group in an environment that was as similar to a normal family as possible, and encouraged ongoing community involvement. This philosophy was formally articulated in 1976 by the Ontario Association of Children's Mental Health Centres (OACMHC, 1977), which adopted the principle of "normalization" as the basis for its standards. Even large non-community-based centres like Thistletown implemented, as much as possible, the normalization concept. In 1972, Thistletown had moved from wards into eight and ten-bed houses on the centre's grounds. It then began to decentralize cooking and housekeeping, which previously had been done by cooks in a central kitchen and by "ward maids", so that these functions became the responsibility of the staff and children in each house.

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28. Carol Dukoff, Browndale (Ontario), personal communication, 1982.
29. Doug Finlay, personal communication, September 1982.

The Chedoke parent-therapist program, started in 1972, was an interesting variation of the trend to ordinary houses on ordinary streets. It placed single emotionally disturbed children and youth in the homes of specially trained "parent-therapists" who provided treatment under the direct and ongoing supervision of mental health professionals from the Chedoke Child and Family Centre. This was an alternative to using professionally staffed community residences with a small group of youngsters(30).

Alternatives to Residential Treatment

The alternatives to residential treatment that have been developed in recent years and are discussed below include day treatment and outpatient services, home care, the use of the child's own parents as therapists, satellite mental health clinics and one-on-one contract workers with adolescents. The use of residential treatment has declined as a proportion of total treatment service as a result.

Day Treatment and Outpatient Services

In 1971, when the Children's Mental Health Centres Act was implemented, there were 327 day treatment places, 198 of which were in licenced children's mental health centres and the remainder in regional centres(31). Day treatment at this time tended to be for younger children, but by 1975 it was being used for the so-called "hard-to-serve adolescent" by East Metro Youth Services and others. The adolescent programs ran all day, five days a week, and had a heavy emphasis on life skills training. Sometimes they were supplemented by outpatient treatment for the family as a whole.

By 1977, there were 1,161 day treatment places(32), and by 1981, these had risen to 1,477(33). The day treatment approach is now used for all age groups and for the full range of problems from behavior disorders to psychosis(34).

Outpatient services to children and adolescents have been provided by hospital clinics since the early 1960s, as discussed earlier in this chapter. Once children's mental health centres became established, they too began to offer this type of treatment.

Home Care

Home care refers to treatment provided by a mental health professional to a youngster and family in their own home. This may range from two or three visits a week for one or two hours each to short-term intensive involvement of up to 12 hours a day in a crisis situation such as a suicidal adolescent.

Home care was being used as early as 1974, when the system was estimated to be able to accommodate 55 families at any one time. This figure was up to 206 families by 1977(35), and rose to 839 by 1981(36). Initially, this approach tended to be a stop-gap measure used by centres to assist families on the waiting list. However, it was soon recognized that home care was a valid treatment in itself, with the advantages of allowing the worker to assist several family members simultaneously and to observe family interaction in the family's own setting instead of the artificial environment of the therapist's office. In 1974, Thistletown, following the lead of other services such as Browndale and Dellcrest, began home care as a deliberate treatment of choice for certain situations (Gilmour-Barrett & Pratt, 1977, p. 81).

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30. Chedoke Child and Family Centre. "The Parent-Therapist Program, Past, Present and Future", internal document, July 1981.
31. Children's Mental Health Services, Provincial Overview, 1971-1976, op. cit.
32. Changes in the Cost and Extent of Service in Children's Mental Health Centres, Children's Mental Health Services Branch, 1977.
33. Caseload as of December 31, 1981, as per CMHSIS.
34. As at Thistletown Regional Centre; Dr. Jeff Sherman, personal communication.
35. Changes in the Cost and Extent of Service in Children's Mental Health Centres, op.cit.
36. Caseload as of December 31, 1981, as per CMHSIS.

Parents as Therapists for Their Own Children in Their Own Homes

Home care uses a mental health professional working in the home and is appropriate for time-limited therapy. However, some mental illness in children, for example, autism, is chronic in nature. In 1977, the Integra Foundation program for autistic children (which later formed its own service known as Geneva Centre) began a two-year training program for parents who were to become therapists for their own children. The first year comprised training in behavior modification techniques through courses, demonstrations by professionals and supervised experience. In the second year, the mental health professionals gradually withdrew as the parents took over increasing responsibility for designing as well as implementing treatment strategies. This approach, which is still being used by Geneva though with some modifications, enabled the maintenance of autistic youngsters at home who otherwise would have been institutionalized(37).

Satellite Mental Health Clinics and Travelling Teams

Provision of mental health services to the north with its large distances and scattered population presents special problems. In many communities, the volume of potential users does not justify the establishment of a service. Nevertheless, it was recognized, in the early 1970s, that removal of a child from his family and home community in order to provide treatment imposes additional stress on the child and results in return to a family where the environment, e.g., pathological modes of parent/child interaction, has not changed.

An early attempt to address this problem was the development, in 1974, of satellite mental health teams in communities such as Fort Frances and Dryden by the Lakehead Psychiatric Hospital (the Thunder Bay regional centre)(38). These teams involved two people, usually a social worker and a psychometrist, who actually lived full-time in the communities they served and had back-up supervision from the hospital. While the plan sounded workable, in practice the teams were undermined by high staff turnover, apparently resulting from the workers feeling isolated and being vulnerable to demands at all hours because everyone in town knew where they lived.

Also in 1974, the Sudbury-Algoma Sanatorium (the Sudbury regional centre) began to establish travelling mental health clinics in communities along the north shore of Lake Huron such as Massey and Espanola. Initially, each clinic was held on a monthly basis with mental health professionals spending a full day in each community. The on-site satellite mental health clinics now functioning in communities such as Espanola and Mindemoya grew out of travelling team experience. Each satellite clinic is administered by a team leader who reports to and is supervised by the Director of the Community Clinic at the Sudbury-Algoma Hospital (as the Sanatorium is now called). Staffing for the clinics varies between communities, but generally comprises nurses and B.S.W.-level social workers. Services from other professionals, such as those of a psychiatrist and speech pathologist, are provided on a visiting basis. The Sudbury-Algoma satellites appear to be working well, and expansion into other communities is planned(39).

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37. Martha Leary, Director, Geneva Centre, personal communication.
38. Facts, Figures, and Forecasts, op. cit.
39. Service Delivery to Smaller Communities in Northern Ontario, paper prepared for North Region of the Ministry of Community and Social Services, 1982.

This positive experience may be a function of the fact that the satellite staff usually number more than two people and thus feel less isolated than those of the Thunder Bay satellites, and the communities are larger so that people have more privacy in their home life.

Contract Workers

In the mid-1970s, several centres began using contract workers to provide service to adolescents in their own environment. In this approach, the youth is assigned a worker who spends several hours a day with him providing counselling and help in daily life tasks such as finding somewhere to live, shopping and getting a job. Perhaps one of the best known uses of contract workers is OPTIONS, which began in 1976 as a joint program of the Ministry of Correctional Services (then responsible for juvenile delinquents) and Central Toronto Youth Services (CTYS)[40].

The Decrease in The Use of Residential Treatment

There will probably always be some youngsters who, at some time in their life, require residential treatment, for example the severely depressed suicidal teenager. But the use of residential treatment is definitely decreasing, both in terms of average length of stay, as discussed earlier, and in terms of the proportion of youngsters receiving mental health services who are in residential treatment, as shown by Table 32.

Table 32

Patterns of Residential Treatment by Children's Mental Health Centres

Year	Incidents of Service to Children as Inpatients	Incidents of Service to Children as Outpatients (1)	Ratio of Inpatient to Outpatient Services
1977-78	1,932	14,581	1:7.5
1978-79	2,145	21,695	1:10.1
1979-80	2,070	24,954	1:12.1
1980-81	1,962	26,796	1:13.7
1981-82	1,948	36,523	1:18.7

1. Includes children served in assessment, outpatient counselling, day care, home care and follow-up.

Source: Information Support Unit, Ministry of Community and Social Services, Finance and Administration Branch, using CMHSIS.

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[40] Presentation to Management Committee, June 8, 1976, Children's Mental Health Services Branch.

Cross-Service Stream Impacts

As indicated in the previous chapters, none of the streams considered in this paper can or do operate in isolation. Of particular significance for the children's mental health service stream have been the cross-stream impacts of:

- the provision of 100% operating funding for licensed Children's Mental Health Centres in 1971
- the repeal of Section 8 of the Training Schools Act effective in 1977
- Section 15 funding under the Education Act.

1. Provision of 100% funding to children's mental health centres: The provision of 100% funding to children's mental health centres encouraged private referrals since there were no longer user fees. The result was that the ratio of children's aid society and Crown wards to non-wards in residential treatment was exactly reversed within three years (Rae-Grant, 1977, p. 170). The societies, which formerly were in a preferential position with respect to obtaining residential treatment for their wards, were now in competition with everyone else. Not only did they therefore have to continue to pay per diem rates in children's institutions and children's boarding homes for some disturbed children, they also found that at least some children's mental health centres discriminated against society wards. A few centres were quite open in stating their preference to work with children who had a family to return to rather than to treat a child in isolation. Due to the demand for residential treatment and the elimination of user fees, the centres had no difficulty filling beds with such children. This prompted some societies to begin finding foster homes that would guarantee the child a placement after discharge from treatment and where the parents were willing to be involved in the child's treatment and have him on weekends. While this sometimes gained access to residential treatment for a child who might have otherwise been rejected, it also increased the cost for the society, which then had to retain a home that was not being used full time.

2. The repeal of Section 8: As discussed in chapter 3, Section 8 was the part of the Training Schools Act under which youngsters presenting non-delinquent control problems were committed to training school. The reason for such committals was often simply to control the child. However, by the early 1970s there was a growing belief that removal of the child to a residential institution begged the question, and resources ought to be used, instead, to enable the family and school to maintain the child in his own community. While sympathy with the intent of the repeal was common in both the child welfare and the children's mental health systems, both found themselves stressed as a result of its implementation.

   Removal of the Section 8 option increased referrals to both the children's aid societies and the children's mental health centres. A briefing document developed in April 1977 for the then newly appointed Executive Director of Operations for the Children's Services Division noted that there is "more demand due to the Repeal of Section 8 than two years ago" on the children's mental health system.

3. Section 15 of the general legislative grants regulation under the Education Act: This part of the regulation provides for funding of a local board of education that supplies a teacher and equipment for a special classroom in a residential setting that, in turn, is responsible for provision of classroom space and someone, usually a child care worker, to assist the teacher. The impact of this arrangement on the children's mental health system has been mixed. On the positive side, it enabled the provision of schooling by certified teachers who were supervised by the local board of education for a number of youngsters who could not realistically be accepted into local schools. On the other hand, it may, to some extent, have worked against the principle of normalization by removing some motivation to pressure the board to admit children in treatment into its ordinary classes. To the degree that the latter occurred, Section 15 may have inadvertently encouraged segregation of some children when their level of functioning did not require it. Hiring child care workers to assist children with behavioral problems to remain in an ordinary classroom, as was done as early as 1974 by the Peel-Dufferin Catholic School Board, is a practice that is much more consistent with the principle of normalization.

Summary of Trends in Children's Mental Health

Before 1950, the mental health services that were available to children were provided mainly through clinics, psychiatric units in general hospitals, and provincial mental hospitals. Opened during the 1950s, most of the first residential treatment centres specifically for children were developed in hospital-like settings. Programs started in the mid-1960s and later began a trend to ordinary houses in residential neighbourhoods. Despite these additions to existing facilities, the capacity and distribution of resources did not meet the demand for service. Moreover, there was little service for preschoolers or adolescents. Because the services were largely user-financed, the cost of service was prohibitive for most families.

Provincial policies established in the later 1960s stimulated the development of a fully funded system of children's mental health centres providing both residential and, increasingly, a range of non-residential services. Non-residential services that help children remain with their families while receiving treatment include day treatment, outpatient services, home care, work with parent therapists, contract work with adolescents, and travelling clinics. While the volume of non-residential service provided by children's mental health centres has increased greatly in recent years, residential service has declined slightly, and thus is a decreasing portion of the centres' total service.

6. RESEARCH ON TREATMENT EFFECTIVENESS

This chapter presents a review of the literature on both residential and non-residential treatment programs for juvenile delinquents and emotionally disturbed children that suggests that some treatment approaches do work. This review covers 25 published research reports where the research design is reasonably acceptable, outcome measures appear valid, and sufficient information is provided on the approach used to give some indication of what might have contributed to the reported success.

These findings of the review are discussed in detail in sections on:

- the importance of evaluating the effectiveness of treatment
- methodological issues
- evaluation of residential programs
- evaluation of non-residential programs
- the program implication of the findings.

The references in the chapter are contained in the bibliography at the end of the paper.

The Importance of Evaluating The Effectiveness of Treatment

McCord and Sanchez (1982) note that during the last decade, several well-publicized studies have proclaimed that nothing works in rehabilitating young criminals. As a result:

> the general public has demanded increasingly punitive action against delinquents: laws have become harsher, and a number of well-known criminologists, like James Q. Wilson of Harvard and the late Robert Martinson of City College in New York, have advocated locking up delinquents for a minimum of three years, whatever their offense. And in Massachusetts a new "get tough" mood among state criminal justice officials has created a movement to re-establish prisons for teen-age offenders (p. 79).

Similarly, in the mental health field, there has been a growing belief that "there is little evidence that the most common serious childhood disorder, conduct disorder, responds well to the treatments currently available"(41). Such negative assessments of the likelihood that treatment will be effective lead to a lessening of public support for funding treatment services. When this occurs in a period of financial constraint, it becomes essential to be able to justify continued fiscal support on the basis of hard evidence regarding effectiveness and efficiency of specific approaches.

However, as noted by Whittaker (1979), the impetus for program assessment and evaluation is not simply due to lack of public support. We need to learn more about what works and what does not in children's treatment so that practice can be based on a solid foundation of data. This is particularly true in regard to residential care, since it is the most intrusive method of attempting to change a child's behavior or meet his needs. It has even been suggested that in some situations, it may be harmful to the client. Easson (1969) points out that:

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41. Report of the U.S. President's Commission on Mental Health, 1978, Volume II, Appendix, p. 38.

- The external structure imposed on a teen-ager by a residential program may work against a healthy resolution of the emancipation-individuation task of adolescence by perpetuating emotional dependence.

- Placement in a residential setting may result in a permanent negative self-image by confirming the adolescent's view of himself as "mad" or "bad" and therefore having to be removed from the community.

Johnson (1982) suggests that residential care should be used with caution for either adolescents or children, since:

- There is a danger that the individual will adapt to the needs of the institution while ties to family and community wither.

- The values and expectations of the residence may deviate from those of the child's family, making post-discharge adjustment difficult.

Other writers have expressed the concern that since much behavior is determined by the individual's environment, desired behavior changes occurring in residential treatment may not generalize to the child's home and community (Davidson & Wolfred, 1977; Nelson, Singer & Johnson, 1978). This is an extremely important issue. As Nelson et al comment, the only gains that matter are those made in the environment to which the child returns.

Methodological Issues

While the importance of treatment evaluation is clear, how it should be done is not. Johnson (1982) states that research into the effectiveness of treatment is plagued by serious methodological problems. For example:

- Criteria for diagnosis, treatment and outcome are not sufficiently well defined for research purposes.

- Client groups tend to be small and heterogeneous, so that it is difficult to compare them.

- Most studies are done without controls, so that the factor responsible for change, if it occurs, cannot be specified. In other words, it is often impossible to tell if "improvement" was due to treatment, maturation or some other factor.

In expressing these criticisms, Johnson echoes earlier writers such as Maluccio & Marlow (1972) and Whittaker (1978) who suggest that the verdict is still out on treatment effectiveness because of such methodological concerns.

This position assumes that the only legitimate evaluation is one that meets the criteria of the classical experimental design and has, at a minimum:

- a control group of matched subjects

- uncontaminated pre- and post-treatment evaluations, e.g., measures from other than the therapist or client, and

- follow-up of both groups (Meehl, 1955).

However, as Randall & McClure (1974) point out, in the mental health field the use of a control group and random assignment to treatment is often not politically feasible. Schulberg (1977) agrees. He states that the relevance of the traditional experimental model for treatment evaluation is increasingly being questioned because:

> the model's key requirements can rarely be met - for example, patients often cannot be assigned randomly among groups - many programs simultaneously employ multiple clinical interventions and key sources of variance cannot be controlled (pp. 565-566).

Schulberg notes, as do other writers, that there is increasing acceptance of a methodology that compares the child's current functioning level with previous functioning levels (Durkin & Durkin, 1975; Mordock, 1979; Nelson et al, 1978). One common method used is a derivation of "goal attainment scaling". This consists of pre-treatment selection of goals, then the development, for each, of a scale of likely outcomes ranging from least to most favorable and stated in terms of observable behaviors (Kiresuk & Sherman, 1965). The child's functioning after treatment is then measured against the scale. A total program can be evaluated by aggregating the progress of several children who have been treated in it. Other methods are pre- and post-treatment measures using standard psychometric scales such as the Quay-Peterson Problem Check List and the use of behavior frequency and/or duration counts. Behavior frequency counts refer to noting how often a particular behavior occurs, e.g., hitting, and comparing the frequency with that noted previously. Duration counts measure the length of time each episode of behavior lasts. Generally, this method is used in behavior modification programs to determine whether or not "target behaviors" are being changed.

In summary, much program evaluation literature was rejected in the past because it did not adhere to classical experimental design. There are now a growing understanding and acknowledgement of the valid constraints associated with clinical research, e.g., the impracticality of insisting on control groups as a criterion for acceptance of a study. In recent years, there has also been the development of more feasible evaluation methods such as goal attainment scaling. However, the body of acceptable research studies remains small. Many of the so-called outcome evaluation reports reviewed for this paper were anecdotal descriptions of a program with a statement that improvement resulted but no supporting data. This experience appears similar to that of a national panel of U.S. social scientists that commissioned an independent study of 231 assessments of programs for delinquents. The panel summarized the results of this technical review as follows.

> To conclude, the panel believes that there is not now in the scientific literature any basis for any policy or recommendations regarding rehabilitation of criminal offenders. The data available do not present any consistent evidence of efficacy that would lead to such recommendations, *but the quality of work that has been done and the narrow range of options explored militate against any policy reflecting a final pessimism* (National Academy of Sciences, 1979, p. 34, italics added).

Similarly, in regard to the assessment of treatment programs for emotionally disturbed youngsters, Barker (1978) notes that there are problems in:

> defining the population treated; assessing precisely what does happen in what is inevitably a very complex process; deciding what constitutes improvement; determining the outcome and how it differs from that to be expected in the light of the natural history of the disorder. None of these problems has been fully overcome in any published study, no entirely satisfactorily evaluated treatment program has apparently been reported. *Nevertheless, outcome data do exist, and there are some suggestive findings* (p. SS-2, italics added).

Evaluation of Residential Programs

Programs for Juvenile Delinquents

Outcome studies with suggestive data exist in regard to the treatment of juvenile delinquents as well as some pertaining to emotionally disturbed youngsters as noted above. Twenty-one evaluation reports, all considered by the authors to be scientifically acceptable, were published in 1980 in a book titled *Effective Correctional Treatment* by two Canadians living in Ontario, Robert R. Ross and Paul Gendreau. To be included in the Ross and Gendreau book:

> a program must have been conducted within an experimental or quasi-experimental design, must have included follow-up assessment of delinquent or criminal behaviour, and must have provided a statistical evaluation of outcome data (p. xiv).

Insisting on such criteria severely limited the number of qualifying studies. Ross and Gendreau note that of all the articles they reviewed, only a small number presented any outcome data, and "of those that do provide outcome data, the adequacy of the research is, in most cases, questionable" (p. 47). Nevertheless, they did find some studies that demonstrate that some types of residential treatment are effective with some types of juvenile delinquents.

Most of the programs described by Ross and Gendreau as having acceptable methodology are based on a social learning (behavior modification) approach to the treatment of the delinquent. Their review highlights an interesting discrepancy between the usually negative findings when this approach is used in institutions and the generally more positive reports from community-based (group home) programs using it. Ross and Gendreau note that correctional institutions tended to implement social learning using existing staff with little or no training in psychology.

> Beginning with the early 1960's up until 1974 it became almost customary to affix the label "behaviour modification" to corrections programs, particularly incentive programs, which had been in existence for decades before the beginning of laboratory investigations of operant conditioning. Unfortunately, the label was also applied to many programs which were exclusively punitive...
>
> Our review of the published literature made it quite clear that as a rehabilitation tool the kind of behaviour modification used in correctional institutions (typically token economy, programmed learning, contingency management) was singularly unimpressive (p. 45).

On the other hand, the community-based programs demonstrating successful use of the social learning approach with juveniles, such as the Achievement Place model (Braukman, Fixsen, Phillips & Wolf, 1975; Phillips, Phillips, Fixsen & Wolf, 1973), are operated by specially trained "teaching parents" under the supervision of a psychologist. These programs produce results such as reported by Phillips et al (1973). They compared a group of youths receiving the Achievement Place treatment with both a control group sent to a state institution and one placed on "formal probation". Two years after treatment, 53% of the boys from the institution and 54% of those who had been on parole had committed a delinquent act that resulted in their being readjudicated by the court versus only 19% of the youths who had been in the Achievement Place program. Among youths still attending school two years after discharge, the overall grade-point average for institutionalized youths was D minus and for boys who had been on parole was D plus, while for those who had been at Achievement Place it was C minus.

One of the factors causing the discrepancy in the results of using the same theoretical approach in two different types of residential settings may be the degree to which staff understand the approach and offer a bona fide social learning program. This hypothesis gains support from the fact that the only institutional program using a social learning theory approach, having what Ross and Gendreau consider sound methodology, and reporting a positive outcome was implemented by trained staff with ongoing supervision from a psychologist (Jesness, 1975).

Shamsie, who also works in Ontario, reviewed 12 studies on the outcome of institutional residential programs for delinquents, all with control groups and follow-up (Shamsie, 1981). He reported his findings, divided on the basis of theoretical approach used, as follows.

Table 33

Outcome of Institutional Residential Programs for Delinquents

				Outcome	
Theoretical Approach	No. of Cases	No. of Studies	Positive	No Difference	Negative
Milieu Therapy	2,399	8	1	6	1
Therapeutic Community	867	4	0	3	1

Source: Shamsie, 1981.

From the above it appears that neither milieu therapy nor the therapeutic community approach is successful. Shamsie also reviewed a number of studies where behavior modification (social learning theory) had been used on either a residential or a non-residential basis. Out of 14 studies, eight had a positive outcome, and in six there was no difference between the control and experimental groups.

Shamsie suggests:

> The unsatisfactory results with the present methods may be due to our perception of antisocial behaviour as a sickness rather than a lack of socialization...
>
> It may make more sense to visualize antisocial behaviour in adolescents as a problem arising from lack of socialization, which was caused by inadequate attempts to teach socialization at an early age, or by a defect in the learning ability of social norms. If the problem has arisen because of lack of proper teaching of social norms at an early age, then we should act as educators and develop programs of socialization...
>
> There is some evidence that programs developed along the above lines are more successful. There are a number of studies showing the effectiveness of social learning programs, which are really concentrated efforts towards teaching social norms (p. 362).

One particularly successful use of specific training of delinquent youth in expected behavior is reported by Walter & Mills (1979) and discussed in this chapter on pages 73, 85-87 and 92.

A review of the studies reporting successful outcome from residential treatment for delinquents suggests several factors that may be correlated with desired change. Discussed below, these are:

- the quality of staff/youth interaction
- the degree to which the youth feels responsible
- work with the family to which the youth will return
- matching of program approach to client type.

1. The quality of staff/youth interaction: The Achievement Place model (Phillips et al, 1973) is a token economy involving the use of instruction and points, rewards or fines contingent on behavior. Each youth carries a "point card" with him at all times on which every reward and fine given him is written. At the end of a certain time period, the number of points made and lost is added up with the point balance providing the currency required to buy privileges. On the surface, the critical factor for success appears to be whether or not staff are consistent in giving rewards and fines. However, when Phillips et al made their first attempt to replicate their highly successful program it failed. They noted that technically, the new home was the same in nearly every way as the older one, and that the token economy appeared to be adequately administered. However, careful observation of the teaching-parents in action showed that they interacted with the youths in a stern manner, assigned tasks in a negative fashion, and gave little praise. In contrast, the teaching-parents in the first home made much use of praise and even when correcting youths used a positive manner. Phillips et al concluded that the type of staff/youth interaction, was a crucial component. They began making videotapes of interactions and teaching staff specifically how to interact effectively. Following this, they have been able to establish other successful Achievement Place homes.

McCord & Sanchez (1982) compared the records of former inmates of two reform schools 25 years after their release. One school (Wiltwyck) was an unwalled setting in which staff combined various forms of individual and group psychotherapy, avoided punishment, encouraged self-government, and tried to build "a community of understanding". The other (Lyman) was "essentially a jail for teen-agers". "The staff emphasized punitive discipline, enforced strict rules, and added a dash of vocational training" (p. 79). According to the authors, the boys in the two institutions were demographically similar in that they were within the same age range, had comparable intelligence, and came from similar social classes and urban backgrounds. They also apparently had committed similar types of crimes. Ethnically, they were different, with a larger number of blacks and Hispanics at Wiltwyck. In 1980, 25 years after discharge, McCord and Sanchez studied the records of 175 men from Wiltwyck and 165 from Lyman who had been in the respective institutions for at least 18 months. They found that:

> Measured in terms of conviction rates for felony offenses Wiltwyck graduates had a 9% recidivism rate in the first five years after their release, as opposed to 67% from Lyman alumni.
>
> During the critical age period of 15 to 24 - when, according to FBI figures, people are most likely to commit serious crimes - 16% of Wiltwyck's graduates committed such offenses compared with 22% of Lyman's men...During the ages between 15 and 19, 34% of the Wiltwyck boys who were status offenders committed felonies; 50% of the Lyman status offenders were convicted for similar crimes (p. 81).

While the evidence strongly suggests that in the first few years after their release the Wiltwyck boys did better, the rate of recidivism of Wiltwyck men in their 30s and 40s was higher than that of Lyman men. By the age of 35 to 40, 32% of Wiltwyck alumni were still committing felonies as opposed to only 8% of those from Lyman. McCord and Sanchez hypothesize that the apparent reversal in the effects of the two schools was related to the different ethnic backgrounds of the two populations. They note that in both schools the recidivism rates of blacks - and Hispanics - went up as age increased, and suggest that this is directly correlated with the discrimination in education, jobs and housing that they experienced. The authors hypothesize that discrimination in the outside community was particularly difficult for blacks and Hispanics who had been at Wiltwyck, where their experience had been one of equality with whites. In regard to the suggested importance of employment, it is interesting to note that Walter & Mills (1979) have shown that getting a job and holding it appears to prevent commission of further antisocial acts by the adolescent juvenile delinquent. Similarly, Shore & Massimo (1979) in their follow-up study of youths 15 years after treatment suggest that obtaining and holding a job is linked with decreased recidivism. The McCord and Sanchez study, in addition to suggesting the importance of the type of staff/youth interaction, may also illustrate the importance of programs that realistically prepare the youth for the environment he will face after discharge, and provide the skills he will need to cope with it.

McCord (1982) also presents evidence that the Wiltwyck approach is successful with child psychopaths. McCord defines a psychopath as "an asocial, emotionally and physiologically insensitive person, who feels no guilt and is unable to form emotionally affectionate relationships with other people" (p. 4). Child psychopaths composed approximately one-third of the population of both schools, and came from "more emotionally barren, deviant environments" than the other children. Recidivism rates among the psychopaths and the other youths following release from the schools are compared below.

Table 34

Recidivism Rates Among Reform School Alumni

	Psychopaths			Others		
Age	Wiltwyck %	Lyman %	Ratio	Wiltwyck %	Lyman %	Ratio
15-19	11	79	1:7.2	8	55	1:6.9
20-24	12	14	1:1.2	17	24	1:1.4
25-29	46	39	1:0.8	20	14	1:0.7
30-34	36	29	1:0.8	15	6	1:0.4
35-40	33	19	1:0.6	19	3	1:0.2

Source: McCord, 1982.

At both schools, psychopaths exceeded other types of inmates in the commission of felonies in every age group except 20 to 24. Up to the age of 25, non-psychopaths released from Lyman were convicted of felonies more often than were psychopaths from Wiltwyck. McCord concludes that Wiltwyck's

> most potent effect was on psychopathic children who developed consciences, absorbed new codes of ethics, and identified with helpful adults (p. 262)...*It would appear that the general Wiltwyck environment had a positive effect on psychopaths during the first 5 years after their release*. In later life, a majority of ex-inmates from both schools were not convicted for later crimes - undermining the belief that psychopaths continue forever as incorrigible criminals (p. 263, italics in original).

2. *The degree to which the youth feels responsible:* In addition to concluding, from the original failure to replicate the first Achievement Place home, that staff/youth interaction affected outcome, Phillips et al (1973) decided that the degree to which the youths felt some responsibility for themselves was important. In the Achievement Place program, the youths are encouraged to take responsibility for themselves through what Phillips calls a "semi self-government system". Basically, this is a daily staff/youth meeting that includes discussion of consequences for rule violation and participation by the youths in all decision-making on items that will affect them. This is believed to mobilize peer group pressure for pro-social behavior, and to encourage the youths to feel some ownership of the decisions made. Phillips et al consider self-government one of the three essential components for a successful Achievement Place program.

   In Ontario, Ross & McKay (1976) established a behavior modification program in a training school for 13 to 17-year-old "unmanageable" delinquent girls, and found that in comparison with a control group they showed more behavior problems in the institution and a higher recidivism rate. When the staff-operated token economy program was dropped in favour of training the girls to act as therapists for each other, behavior in the institution improved, and recidivism decreased in comparison with a control group. The total number of behavior problems reported by aftercare officers during the girls' first nine months after discharge was 26 for the 15 girls who had been in the peer therapist program and 85 for the 15 in the control group. Ross and McKay note that their peer intervention approach recognizes that the most important influence on the adolescent offender is his/her peers, and their method encourages peer pressure for pro-social behavior. Also,

> In our token economy the girls saw their behaviour as dependent on external rewards and contingencies. Thus, there was no reason for their behaviour to persist once they left the institution and the environmental contingencies changed...In the peer therapist program...the girls saw themselves responsible for any changes that occurred to them (p. 398).

3. Work with the family to which the youth will return: Not all community-based social learning theory approach programs report success. Davidson & Wolfred (1977) compared a group of adolescents who, they state, received a program similar to the Achievement Place model described by Phillips et al (1973) with a control group receiving no treatment. All the treatment group demonstrated significant improvement in behavior while in treatment. However, three months after discharge, they had more contacts with authorities stemming from juvenile offences than did the control group. In addition, at both post-discharge evaluation points, the control group had a better school attendance record. Finally, the authors note that there was no statistically significant change in pre- and post-treatment measures on school grades, school attendance or contacts with police for the treated group. Davidson and Wolfred offer several divergent hypotheses to explain these findings, including the statement that while residence staff consistently advocated for post-discharge placement in the youth's natural family, they were overruled on several occasions by the state, and the adolescent was placed in an institution. This suggests a major difference between their program and the Achievement Place model developed by Phillips et al (1973), which emphasizes the importance of practice weekends for the youth in his post-discharge home prior to completion of treatment (Phillips et al, 1972). The failure of Davidson and Wolfred to duplicate the success of Phillips et al may demonstrate the importance of working with the youth in the environment to which he is to return rather than indicated failure of the treatment approach. Support for this hypothesis comes from outcome studies of residential programs for emotionally disturbed youngsters, as discussed on pages 88 and 89 of this chapter.

4. Matching program approach to client type: Sarason & Ganzer (1973) compared the effectiveness of modelling[42] versus discussion groups on the development of awareness in delinquent adolescents of what constitutes socially acceptable behavior and the subsequent recidivism rate of the two experimental groups and a control group. Both experimental groups showed less recidivism than the control group, but there was no statistically significant difference between them. Within the experimental groups, boys responded differentially to the treatment condition. In a retrospective examination, the authors found that among the youths experiencing the modelling approach and showing a positive outcome, a disproportionate number had been given the diagnostic label of neurosis or passive-dependent personality. Case records described these boys as passive and markedly deficient in verbal skills. Of the youths who showed improvement after the discussion groups, a disproportionate number had been labelled passive-aggressive or sociopathic. They were described in case records as socially active, hostile and verbally aggressive.

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[42] Demonstrations in the form of modelled behavior (role playing) observed by the youths.

Jesness (1975) in his study comparing a behavior modification program with a transactional analysis program found that the aggregate data indicated that both programs significantly reduced aggressive behavior and recidivism. However, examination of individual data indicated differences in outcome between the two approaches that appeared to be correlated with differences in youth personality types. Recidivism rates among youths who had received the behavior modification program and were diagnosed as "situational emotional reaction types" (manipulators) were significantly lower (20%) than for youths in the same program who were labelled "unsocialized passive". Palmer (1974) and Barkwell (1980) have also suggested that youths with different personality types show different outcome with the same treatment approach in a non-residential program, as discussed on pages 83-84 and 92 of this chapter.

Pauker & Hood (1979) investigated the use of the following systems for matching staff to youths in care:

- the Interpersonal Maturity Level (I-level)
- the Conceptual Level
- the Moral Development System, and
- the Quay Dimensions Classification System

through seven on-site visits to programs using one of them, a literature review and discussions with key informants. They found that positive treatment effects were reported in some places where classification systems were in effect. Also,

> classification was regarded as a worthwhile venture by almost everyone with whom we talked and regardless of the particular classification system (p. 48).

However, they note that the results of research studies on classification systems are sometimes suspect because of faulty design or limited application of a differential approach to treatment. Nevertheless, Pauker and Hood do recommend that serious consideration be given to the matching of worker styles and child characteristics.

In conclusion, the above discussion indicates that there is some evidence that residential treatment can be effective with youngsters labelled "delinquent". However, as Ross and Gendreau caution, "No program is touted as the final answer. No program is recommended for all offenders" (p. xiv). They go on to add that:

> we urge the reader to pay careful attention to interaction effects: the outcome of each and every program will depend on a host of factors including the type of offender, the type of treatment, the nature of the treatment setting, the characteristics of the practitioners, the intensity of their treatment efforts, the program goals, and the nature of the post-treatment environment, among others (p. xiv).

Programs for Emotionally Disturbed Youngsters

As noted earlier, there is growing support for the legitimacy of goal attainment scaling as a method of program evaluation (see page 69). This method was used by Nelson et al (1978), who studied 22 pre- and early adolescent children by obtaining pre-admission information on functioning in the family and school, then comparing it with information obtained just after admission, just before discharge and three to five months after discharge. They report that at the time of discharge, 97 out of 116 prestated goals had been successfully achieved. The authors classify the post-discharge placements of the 22 children as:

- 5 non-support environments, e.g., neither parents nor school attempt to reinforce desired behavior
- 17 in varying degrees of a positive support environment, e.g., parents and/or school reinforce desired behavior.

Nelson et al report that:

> those 17 children who were part of some supportive system maintained 75% of their goals after discharge from the treatment center. In contrast to this, the 5 clients who did not have benefit of the support environment but who were non-support cases maintained only 50% of their treatment goals after discharge (p. 170).

As the authors note, their sample was small. However, the apparent influence of the post-discharge environment on the maintenance of gains made in treatment is important. Since this study is reported briefly as an illustration in a paper discussing an evaluation model, Nelson et al do not provide as much detail as might have been provided otherwise. For example, they do not describe the treatment approach or define the "reinforcement" used by parents or schools, nor do they provide information such as whether attempts had been made to work with the parents and teachers in the "non-support cases". Nevertheless, their suggestion about the importance of the post-discharge environment supports conclusions drawn by earlier investigators such as Allerhand, Weber & Haug (1966) and Taylor & Alpert (1973).

Allerhand et al did a retrospective study of 50 boys two years after discharge from a milieu approach treatment. The authors collected data from the centre's records on each child three months after admission, 15 months after admission and at discharge. They then conducted approximately one to one and one-half hour interviews with each boy, his parents and his therapist. All the above data were rated by trained judges, two judges independently rating each subject's material, using scales developed by the investigators. The focus of the study was the youths' adaptation to the expectations of life in the community, e.g., appropriate peer relationship skills and the relationship of these to the youths' current living situation, which was rated in terms of being stressful or supportive. The authors do not provide criteria for defining level of adaptation or environmental supportiveness or copies of the scales used. They state, however, that there was from 79% to 93% inter-judge agreement. At follow-up, 71% of the boys were judged to be showing adequate functioning, and 68% were judged to be in living situations that were at least partly supportive. Comparing these data with in-treatment functioning, Allerhand et al concluded that post-discharge functioning was more related to whether or not the post-discharge situation was supportive or stressful than to treatment gains made in residence.

Taylor & Alpert (1973) also specifically examined how children adapted to the community after discharge from residential treatment and the degree to which post-discharge environments were supportive or stressful. They studied 75 children using a version of the Roen-Burns' Community Adaption Scale and evaluation of the environment's supportiveness on the basis of the child's perception of the availability of help. Taylor and Alpert concluded that post-discharge community functioning and maintenance of gains made in treatment was directly correlated with:

- the degree to which the child lived continuously with his own or adoptive parents after discharge
- the child's perception of the degree of support and help available from such people as parents, relatives and staff at the treatment centre.

On the basis of these studies, Durkin & Durkin (1975) suggest:

> extensive aftercare is essential to marshalling family and community support for sustaining and augmenting gains in treatment...it is evident that the effects of residential treatment can be undone or supported and augmented, depending upon the nature and extent of aftercare services (p. 291).

Mordock (1979) agrees, stating that:

> Supports and services received by the child and his or her family following residential care seem more significantly related to eventual outcome for a child than the degree or kind of emotional disturbance displayed either at admission or at discharge (p. 195).

In an Ontario study, Rubenstein, Levin, Armentrout & Herald (1978) compared the effectiveness of treatment in a residential children's mental health centre with treatment in a parent-therapist program. The parent-therapist program involved placing individual emotionally disturbed children in the homes of specially trained foster parents who then provided 14-hour care and treatment under professional supervision. Referrals to the two approaches were made on the basis of bed availability, and so were, in a sense, random. The average age of the children was 9 years 4 months with a range from 6 to 12 years, both groups remaining in treatment for an average of 18 months. The children were assessed for behavior problems using the Quay-Peterson Problem Check List before entering the program and at discharge. At admission, all children in both groups displayed "severe behavioral disturbance" according to the Check List, and data are presented showing that there was no difference between the two groups in the severity of behavior at the initial assessment. Both groups showed significant improvement in behavior according to the Quay-Peterson, but this was not related to the treatment modality to which the child had been assigned. In other words, both approaches appeared to have had the same effectiveness. However, "treatment in the Parent-Therapist Program was half as expensive as treatment in a residential centre" (p. 660). Nevertheless, in 1981 the Parent-Therapist Program was terminated. Part of the reason was that the intent, right from the beginning, had been to do a demonstration project only. However, the following factors were also important considerations(43):

- On the basis of experience, it was concluded that some children were so draining on a 24-hour basis that they stressed the parent-therapist to the point of threatening marital stability. Residential treatment centres may better be able to handle such youngsters, since rotating shifts provide staff with some relief.
- Some youngsters who had had multiple placements had great difficulty trying to relate to a "parent" in a "family" situation. For an adolescent, who should be beginning to separate from parents, it may not be appropriate to use a "parent-child" relationship if this is stressful. Instead, the multi-placement adolescent who is reluctant to be involved with a family may be better treated in a centre with a strong emphasis on life skill training for independent living.

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43. Fran Pilon, Parent-Therapist Program, personal communication, September 1982.

Rubenstein et al also note that "there is marked variability in outcome; in both groups there were some children who showed decided improvement but others who showed little or none" (p. 660). This seems to suggest, as indicated in the earlier discussion of the effectiveness of residential treatment with delinquents, that residential treatment is effective for some emotionally disturbed children, but no one approach is suitable for all.

Evaluation of Non-residential Programs

Non-residental Programs for Juvenile Delinquents

Shamsie (1981) also reviewed non-residential programs for delinquents; again, all the studies he reports on had control groups and follow-up data. His findings, divided on the basis of therapeutic approach, were as follows.

Table 35

Outcome of Non-residential Programs for Delinquents

Theoretical Approach	No. of Studies	No. of Cases	Positive	Outcome No Difference	Negative
Casework	10	5,356	0	9	1
Individual Psychotherapy	10	1,648	2	6	2
Group Counselling	27	1,867	9	17	1
Family Therapy	12	2,184	4	6	2

Source: Shamsie, 1981.

From the above studies, family therapy and group counselling would appear to be the most effective types of intervention.

As Shamsie notes, many different methods are used to involve a family in family therapy and "therefore almost every study has a slightly different slant" (p. 360). Two out of three studies he reviewed that used short-term family crisis counselling reported success, and one showed no difference in outcome between the control and experimental groups. From this, Shamsie tentatively suggests that family therapy may be most successful with delinquents if initiated at the time the family is in crisis, that is, at the time of the youth's arrest.

Shamsie's tentative conclusion is supported by research done by Wade, Morton, Lind & Ferris (1977) and by Alexander & Parsons (1973). Wade et al did not use a control group. They explain this on the basis that their research was done in a service agency that accepted all referrals. The Wade et al study used graduate student volunteers to provide counselling to teen-agers and their families on a short-term basis. Treatment was initiated immediately after referral from court. The approach used was a combination of:

- involvement of the counsellors as models
- development of intellectual understanding of the causal relationships between parental and adolescent behavior
- training of family members in expressing themselves clearly and completely
- exploration of previous coping methods and their inadequacies
- facilitation of active, goal-oriented problem solving focussing on the present and future
- use of behavioral contracts and training in negotiating skills.

In the first year, 69 families were treated. Of these, 47 had first-offender youths while the 22 remaining adolescents were repeat offenders. Recidivism rates after one year following termination of treatment were 33.6% for the first offenders and 45.5% for the repeat offenders.

To examine the differential effect of treatment, Wade et al then took a sample of 34 successively referred families, and applied the above treatment with goal attainment scaling used as an outcome measure. They found that the 127 goals established by counsellors fell into various categories, the most frequent of which were:

- improved family communication (23.6%)
- increased school attendance (18.9%)
- reduced runaways (13.4%)
- increased acceptance of responsibility in the family (13.4%).

Less frequently set goals included improved relationships with peers and elimination of law violations. In all, 82% of counsellor-set goals were attained at or better than the expected level of success. The successful attainment rate for improved family communication was 73.3%, for school attendance was 70.8%, for runs was 90% and for accepting responsibility in the family was 82.4%. Goals concerning improved relationships with peers were attained in every case, as were goals related to stealing and shoplifting. The above outcome measures suggest that the family therapy intervention used in this study was successful. Maturation is unlikely to be an explanation for the improvement since the intervention was of only a few weeks' duration.

Alexander & Parsons (1973) also offer support for the use of family therapy in the treatment of delinquents. Their study controlled for the possible effects of maturation and/or professional attention by comparing families receiving the research therapy with families receiving alternative forms of family therapy or no formal intervention. The research therapy was a short-term behavioral family intervention program that aimed at systematically extinguishing maladaptive interaction patterns in the family and substituting the use of clear communication of wishes and feelings, clear presentation of demands and negotiation to settle differences. Although the main focus was on modifying the families' interaction patterns, token economy programs were used with some families with younger adolescents for specific target behaviors. The comparison groups received one of:

- a didactic group discussion program focussing on attitudes and feelings about family relationships and adolescent problems
- a psychodynamic counselling program
- no treatment.

Six to 18 months following termination of the various treatment programs recidivism was as follows:

- short-term behavioral approach - 26%
- didactic group discussion - 47%
- psychodynamic counselling - 73%
- no treatment controls - 50%
- county-wide recidivism rate - 51%.

There was no difference between the didactic group discussion program subjects and the control group, while the families receiving psychodynamic counselling showed a higher recidivism rate. The groups that received the short-term behavioral family therapy did best, and showed a lower recidivism rate than the county-wide rate. Alexander and Parsons point out that:

> The fact that treatment and two comparison conditions involved some form of "family therapy" emphasizes that a focus on families per se is not sufficient to modify family interaction patterns or reduce rates of delinquency (p. 139, italics in original).

Instead, they suggest, what is important is focus on changing family interaction patterns in the direction of increased clarity and training in negotiation and contracting that emphasizes the equivalence of rights and responsibilities of all family members.

Shamsie's 1981 review of the literature also identified nine of 27 studies using group counselling and reporting a successful outcome. However, apparent improvement while in therapy did not appear to be maintained when follow-up was done. Shamsie notes:

> Although some studies reported improvement for the time the youth was in treatment, this improvement did not carry over upon release. It appears that the improvement may have been due to the opportunity for the youths to express their feelings in a group while in treatment, but made no significant difference in the recidivism rate (p. 360).

However, Ross & Gendreau (1980) report one study using group therapy with delinquent adolescents where there was reduction in recidivism compared to a control group eight months after termination of treatment. Ostrom, Steele, Rosenblood & Mirels (1971) selected group leaders who were similar to the project participants in ethnic and socio-economic background, plus past delinquent behavior, but dissimilar on the basis of educational achievement and age (college students or recent graduates who were six to eight years older than the subjects). This was a deliberate strategy to maximize the similarity between the delinquent participants and the leaders if advocated changes in behavior were to be effective. A total of seven two-hour sessions extending over a two-month period were held. Role playing was used extensively in addition to discussion of delinquent acts, the consequences of such behavior and alternative means of achieving goals. During the same period, a matched group of control subjects received the usual program offered by the probation office, including individual meetings with a parole officer. During the 18 months after treatment, 26.3% of the experimental group committed at least one delinquent act in comparison with 47.7% of the control group. In addition to the deliberate attempt to match leaders and subjects in the experimental group, this study also addressed the problem of possible conflict with the youth's friendship patterns. This was done through the explanation given the subjects as to the purpose of their participation and by giving them permission to bring friends to the group sessions. The authors believe that this factor is also important for success, and state that:

> One inadequacy of previous delinquency programs was their creation of incompatible group allegiances...(that) would force the participant to reject his preexisting friendship and peer groupings. It might be expected in such a conflict that many would reject the program rather than their friends (p. 227).

Shamsie (1981) found only two reports of individual psychotherapy with delinquents where there was a successful outcome. He notes that one used subjects diagnosed as "amenable" to treatment and the other used a social learning theory orientation, and concludes that:

> This finding is not surprising as psychotherapy is a mode of treatment in which the motivation and co-operation of the patient is an essential element (p. 359).

Lee & Haynes (1980), in an article especially prepared for the Ross and Gendreau reader, report on a series of studies comparing one-to-one individual counselling as an add-on to probation services with the effectiveness of probation alone. The probation workers were seen as having responsibility for "adjusting the child to acceptable standards of behaviour", while the counsellors were to "deal with the child's private world of thoughts, feelings" (p. 172). The aim was to have the experimental group:

- gain in feelings of self-worth and respect
- come to understand themselves better
- accept more responsibility for their behavior and decisions.

A variety of theoretical approaches were used in the therapy sessions, depending on the preference of the counsellor and/or the situation, but the researchers note that the program's orientation "regards behaviour modification in general, and particularly the threat or use of sanctions to affect behaviour, as the appropriate function of the probation officer" (p. 178). Therefore, this particular approach, also known as social learning theory, was rarely used by counsellors. Experimental subjects and controls had to have indicated some willingness to co-operate with treatment. Shamsie (1981) suggests that this is an important variable for success in individual counselling. Outcome for the Lee and Haynes experimental and control groups was:

Table 36

Outcome of Individual Counselling

Year	Criterion	Group	Per Cent
1973/74	Recidivism during the experimental period	34 experimental	24
		31 control	44
1974/75	Recidivism during the experimental period	24 experimental	29
		24 control	50
1976	No. of "acts of misconduct" during the 2 years following treatment	30 experimental	23
		34 control	65

Source: Lee & Haynes, 1980.

Also presented for the 1973-74 group are school performance data showing that the control group had statistically significant higher rates of truancy and suspensions than the experimental group. Grades were slightly higher for the experimental than the control group but not statistically significant.

Although Lee & Haynes (1980) did not comment on the fact that different counsellors used different theoretical approaches, such as reality therapy, there may have been some, perhaps unconscious, matching of client and treatment method. As discussed earlier in regard to residential treatment, this could be an important factor influencing outcome. Palmer (1974) and Barkwell (1980) both report success resulting from matching the delinquent youth's personality type, as assessed using the Jesness Interpersonal Maturity Level (I-level) Classification System, with the probation officer's interaction style. Barkwell's study, done in Manitoba, is a follow-up of Palmer's work. For a six-month period, male juveniles (aged 12-17 years) placed on probation by the Winnipeg and St. Boniface juvenile courts were randomly assigned to one of:

- I-level treatment (including assignment to a worker on the basis of I-level classification)
- alternate treatment
- surveillance by the probation officer in the usual fashion.

By having two treatment groups, Barkwell addressed the possible influence on outcome of attention per se while the control group addressed the influence of maturation. Intervention effectiveness was measured by assessment of a) self-concept measured by the Tennessee Self Concept Scale, b) stability of functioning as measured by days of school and/or work attendance, and c) recidivism over a three-year period. Barkwell suggests that the simple comparison of treatment groups as to the number of reinvolvements in delinquency is too gross a measure of program success. Therefore, he assigned to the original delinquency a severity score that was compared with the severity score of any subsequent delinquent act. In this way, relative seriousness as well as frequency of delinquent behavior were included as variables making up the recidivism measure. Recidivism over the 36-month follow-up period was measured every six months as follows.

Table 37

Outcome of Different Methods of Intervention with Juvenile Probationers

Sum of severity scores for groups in each successive six month block

Group	Months	1-6	7-12	13-18	19-24	25-30	31-36
1-level		53	50	25	22	16	0
Alternate		110	64	92	110	34	18
Surveillance		56	84	98	25	11	36

Percentage of recidivist juveniles in each group

Group	Months	1-6	7-12	13-18	19-24	25-30	31-36
1-level		31%	37%	31%	19%	12%	0
Alternative		50%	44%	25%	19%	12%	19%
Surveillance		56%	69%	44%	25	37%	12%

Source: Barkwell, 1980.

At each time block, the severity of delinquent involvement was lower for the I-level group than the other two, and the difference was statistically significant. However, there was no statistically significant difference in the rate of delinquent reinvolvement among the three groups, although the I-level group showed a trend in the desired direction. The self-concept difference scores (positive increase) of the I-level group were significantly higher than for the other two groups. In addition, although all three groups showed improvement in school/work attendance the I-level group did significantly better than the other two. Therefore, it appears that if all three measures are taken together, the I-level treatment had a better outcome.

In addition to its successful application in residential programs, the social learning theory approach has also been successfully used in non-residential situations. Two reports illustrating this are in the Ross and Gendreau reader, namely the studies of Davidson and Robinson (1975) and Walter & Mills (1979).

Davidson and Robinson describe a program for "hard-core chronic delinquents" who lived in their own homes instead of being sent to a training school. For a 12-month period, all referrals to the program were accepted; therefore, there was no randomly assigned comparison group. Instead, follow-up was done on an average of 18 months after discharge by comparing the youth's functioning at that time with his level of functioning in the year before admission. The program consisted of a contingency point system whereby the youth earned points, which could be exchanged for privileges, in the areas of work performance, academic performance and appropriate verbalizations in group sessions. Each morning the subjects engaged in various work projects in the community, such as litter removal, while they spent afternoons receiving individualized academic instruction. Group sessions held two afternoons a week involved discussion of items such as each subject's positive accomplishments. The program included three hierarchical levels through which the youth was required to move in order to graduate. At follow-up, arrest rates for graduates were a mean of 0.46 per year. This represents a significant reduction from 2.95 per year prior to treatment. However, 27 of the original 125 subjects failed to graduate. The reasons for removal before completion were: a) placement in other programs (11), b) subject's family moved from the community (10), and further law violations (6). It therefore became possible to compare graduates with non-graduates. Arrest rates for non-graduates at the time of follow-up were 0.64 per year. However, the authors point out that this was a rather meaningless measure since 55% of them were in a correctional institution. Comparison on other measures was as follows.

Table 38

Outcome of a Non-Residential Social Learning Program

Measure	Graduates (95)	Non-Graduates (24)(1)
In School	28	0
Employed	33	2
Unemployed	18	10
In a correctional institution	16	12

1. Data on some of the non-graduates were not obtained.

Source: Davidson & Robinson, 1975.

It therefore appears that the program was successful for most of those who completed it. However, no reason is given for the removal of 11 youths to other programs. If these 11 subjects were considered failures there, the success rate of the program would be less since presumably the number unemployed or in a correctional institution would be higher. In the worse case, that is all 11 added to the unemployed/institution group, there would be 45 in that category compared to 61 in school or employed.

Walter & Mills (1979) describe a "Behavioral-Employment Intervention Program" that both significantly increased delinquent youths' attendance on jobs and in school and decreased frequency of arrests. The subjects were adjudicated delinquents with one to eight convictions with a mean arrest rate of 3.85. "Such felonies as arson, armed robbery, rape and larceny were commonly found in the records of the referrals" (p. 189). There was a comparison group similar in age and background that consisted of youths also referred to the program. The intervention comprised:

- training of subjects in basic job skills and positive job attitudes, e.g., attendance, grooming, appropriate office or store manners
- training of employers in the use of positive reinforcement with subjects coupled with weekly supportive meetings of the employer with the experimenter
- establishment of contracts describing the obligations of the experimenter, subject and employer.

Before beginning work (which might be full or part-time), the subjects were asked to list eight behaviors they believed necessary to maintain a job. If they could not produce a list, they were given suggestions to choose from. The subjects took their lists (and subsequent revisions) to their job each day during Phase I, and received points from their employer for each behavior completed. Subjects' points were plotted weekly on individual graphs. Employers also filled out weekly feedback sheets for the subjects' positive job behaviors and behaviors needing improvement. The experimenter then discussed these sheets at weekly feedback sessions with the subjects. When subjects had earned a specific number of points, they received a raise from the employers, and moved into Phase II of the program. This phase involved a reduction of experimenter/subject contact to bi-weekly sessions and completion of check lists only on a weekly basis. Again when subjects had earned a certain number of points they received a second raise, and moved to Phase III. In addition, at this point, the experimenter wrote a letter to the court recommending the subject's release from court jurisdiction. In Phase III there were no formal contacts by the experimenter with either the employer or the subjects. Phase I and II generally took six months. Phase III, also a six-month period, was the follow-up stage.

Walter and Mills used two criteria to measure overall success. The subject should:

- have no further arrests and not have been institutionalized
- be on the job a minimum of three months, and stay in school, or if a drop-out go back to school or into vocational training.

On the basis of these criteria, overall success was 84.9% for the experimental group and 13.6% for the controls. Other outcome data, collected six months after termination of Phase II, were as follows

Table 39

Outcome of a Behavioral - Employment Intervention Program

	Arrests		Institutionalized		Remained in School		Obtained Jobs	Still on Job
	None	1 or more	Yes	No	Yes	No		
Experimental (N=53)	48	6	9.4%	90.6%	85.7%	14.3%	53	18
Control (N=23)	7	16	52.2%	47.8%	33.3%	66.7%	9	0

Source: Walter & Mills, 1979.

Forty-six of the experimental subjects were in school at the beginning of the program, and of this number, 30 remained in school. Some experimental subjects did not maintain their original jobs, but all these cases were considered successful in that they either acquired better jobs, returned to school full-time, or took further vocational training.

In the Ross and Gendreau reader, Walter and Mills discuss how they were able to obtain and maintain 45 employers willing to hire a delinquent and co-operate with the demands of the program. Methods used included:

- personal letters to business leaders explaining the proposed program and asking for their assistance
- a series of radio interviews describing the program plus advertisements in local newspapers
- presentations to local service groups
- ongoing praise and support for employers who participated in the program including public recognition through special luncheons and newspaper articles.

In addition, the program used small businesses where the owner or manager could take a personal interest in the youth and where the youth would not be lost in a large number of employees.

To summarize, the above studies suggest that several factors may contribute to successful outcome in non-residential programs for delinquents. Involvement of the family in the youth's treatment seems beneficial, perhaps because it increases the likelihood of a supportive post-discharge environment, a factor found to be important for success with residential treatment. However, as noted by Alexander & Parsons (1973), "a focus on families per se is not sufficient to modify family interactions or reduce rates of delinquency" (p. 139). Two important factors appear to be:

- initiation of contact shortly after the youth's arrest when the family, presumably, is in crisis
- specific training of family members to express themselves and their wishes clearly and to negotiate.

While it is important to note the apparent value of including the delinquent's family in treatment, this may not be possible. Ross & Gendreau (1980) note that correctional workers come across many families that "adamantly refuse to co-operate with any attempt to involve them in any program effort" (p. 159). Therefore, the studies reporting success without focussing on family involvement are very important. Critical factors for success in these appear to be:

- specific training of delinquents in social norms and skills (Davidson & Robinson, 1975; Walter & Mills, 1979)
- matching client's personality with worker interaction style (Barkwell, 1980; Palmer, 1974)

Ostrom et al (1971) used a variation of matching clients with workers since they specifically recruited group leaders of the same ethnic and socio-economic background as the youths in their program.

Programs for Emotionally Disturbed Youngsters

Patterson (1974) reported successful treatment outcome with "problem behavior" children by training parents in behavior modification (social learning theory) techniques and having them act as their child's therapist. The total treatment time per case averaged 31.5 hours with an average 1.9 hours of consultation during the 12-month follow-up period. According to independent observational recordings, the rate of deviant behavior in the home was reduced by 43%, to a level Patterson defined as "within the normal range" for all children of the same age. This reduction was maintained for the 12 months following termination of intervention by the professional therapist. While this study suggests a high level of success, there is no control for the effect of maturation or additional parental attention.

Similarly, Rinn, Vernon & Wise (1975) also report successful outcome in training parents to use social learning theory principles to reduce temper tantrums, non-compliance and truancy in their children. At the end of the final training session for the 80 cases later followed up, there had been 68-100% goal attainment for problem behaviors in 92% of the children. The authors view this as "marked improvement". Follow-up was done on the 80 randomly selected cases through asking the parents, in a telephone interview, to estimate the frequency or duration in the previous week of what had been problem behaviors for their child. Their estimates were then compared with the frequency or duration that had been recorded at the beginning of treatment. According to Rinn at al, 54% of the reports indicated a significant improvement and only 16% no improvement. No parent reported a level of improvement in a behavior higher than that recorded at the end of the parent training sessions. Parents were also asked to estimate on a scale from one to ten the overall behavior of their child at the time of follow-up compared with his behavior just prior to the course. Forty-one percent estimated overall behavior at 8 to 10 (much improved) and only 12% estimated behavior at 1 to 3 (not improved). As a final outcome measure, parents were asked whether or not they had sought further therapy for their child's problem behaviors after completing the parent training course. Only 16% of the follow-up parents stated that they had sought further treatment.

The reports of both Patterson (1974) and Rinn et al (1975) suggest significant reduction in "problem behaviors" as a result of training parents to be their child's therapist using a social learning theory approach. Both also indicate maintenance of gains over time, but since neither has a comparison group there is no control for the effect of maturation. This weakness is shared by other studies indicating successful outcome that use this treatment method (Johnson & Katz, 1973); Patterson, Cobb & Ray (1973). However, the replication of similar results by several authors lends credence to the suggestion that this is a useful approach with children who exhibit behavior disorders.

D'Angelo & Walsh (1967) and Leventhal & Weinberger (1975) both report successful outcome using non-social learning theory, brief therapy programs to treat school-age children. Leventhal and Weinberger offered two sessions a week, for six weeks, to children and their parents or children alone referred to a mental health centre with some type of behavior problem. The approach was to stress competency and to focus on "specific here and now goals" rather than the child's total personality. Outcome measures immediately after treatment appear to indicate success. However, when the experimenters attempted follow-up 1½ years later, only 36% of the parents responded. Therefore, it is not possible to estimate whether gains were maintained. D'Angelo & Walsh (1967) report on short-term therapy (six months) using a psychodynamic approach with children diagnosed by a psychiatrist as in need of treatment. All children referred were randomly assigned to one of the following:

- control group, no treatment
- child in individual therapy, no treatment offered to parents
- parents in group therapy, no treatment offered the child
- child in individual therapy and parents in group therapy.

Pre- and immediately post-therapy tests, using a variety of psychometric instruments, were done. Subjects who were in the "child only offered therapy" group appeared more disturbed than at pre-testing. Those in the other two treatment groups appeared better as did the control group. D'Angelo and Walsh hypothesize that:

> children who are singled out for special help without their parents' involvement may interpret that their problems are viewed solely as their responsibility—thus, possibly, increasing their insecurity, guilt, and anger in regard to others. The parents might similarly assume that whatever difficulty exists has little relationship to their dealings with the child (p. 63).

The authors explain the apparent positive trend in the group having no therapy as the result of three of the original 14 children being transferred to other schools because they were having academic or behavioral problems. Therefore, "the post-test scores represent a less disturbed group than had the pre-test scores" (p. 62). This may or may not be a valid argument. The D'Angelo and Walsh study does not report any follow-up. As a result, in addition to the questionable explanation of improvement in the control group, it is not possible to determine whether apparent improvement in the two experimental groups was maintained after the removal of professional attention. However, this study is interesting because it alerts therapists to a possible danger in focussing intervention exclusively on the child.

Bauman (1976) reports on outcome six months to six years (on average 2 years 7 months) after discharge from a day treatment program for emotionally disturbed pre-schoolers, many of whom were also functionally retarded or neurologically impaired. The treatment approach used frontline workers as primary therapists for the children with an emphasis on life skill training such as dressing and peer relationship skills. Concomitant family therapy was given by professional social workers. Evaluation was done by comparing the child's functioning at intake, as documented in the centre's records, with a home visit-interview. Bauman reports that at the time of follow-up, 94% of the children were living at home. Of the 62 subjects at home, 40 were in regular classroom placements, 12 in special classes and 10 in a day treatment setting. Since at intake 24 had been diagnosed as psychotic, 24 as having a character disorder, 12 as showing "delayed ego development" and 5 as neurotic, Bauman believes that the fact that most were able to live at home indicates treatment was successful. The lack of objective outcome measurements is a major limitation in this study, as is the lack of a control for maturation given the age of the subjects. However, it does support earlier suggestions that skill development and work with the family are important components of treatment.

To summarize, the studies of non-residential treatment with emotionally disturbed children suggest that:

- Training parents to use social learning theory principles and function as therapists for their own children is likely to be effective in reducing "problem behaviors".

- Involvement of parents in treatment is probably important for a successful outcome (Bauman, 1976; D'Angelo & Walsh, 1967).
- Training in basic life skills may enable the child to function in the community (Bauman, 1976).

Program Implications

As discussed earlier, many studies on treatment outcome are of limited usefulness because of poor methodological design. Particular problems are lack of follow-up after termination of treatment and lack of control for the possible effects of maturation. However, the present review identified 25 published reports where:

- the research design is reasonably acceptable
- outcome measures appear valid, and
- sufficient information is provided on the approach used to give some indication of what might have contributed to the success reported.

Since the purpose of this review was to extract information that might be useful for program development, some studies are included in the above 25 that have methodological problems. These are discussed in their analysis. Generally, they are reports where the outcome is supported by other studies with better design or else the report suggests something of particular interest (e.g., D'Angelo and Walsh; see page 88).

The most important finding is that some treatment approaches do work. There is, however, no universal panacea for all disturbed or disturbing children. Other important general findings are that:

- Successful outcome can result from the use of non-professionals (e.g., Lee & Haynes, 1980; Walter & Mills, 1979; Ostrom et al, 1971) or parents (e.g., Patterson, 1974; Rinn et al, 1975) as therapists under the supervision of professionals. This maximizes the number of individuals each professional can assist.
- Short-term therapy can have a significant impact (e.g., Alexander & Parsons, 1973; Leventhal et al, 1975).
- Intervention does not have to be expensive to be effective (e.g., all the non-residential programs).

The following table illustrates the factors that appear, on the basis of the present literature review, to be associated with success by type of program.

Table 40

Factors Associated With Success by Type of Program

	Residential		Non-Residential	
	Delinquent	Disturbed	Delinquent	Disturbed
1. Involvement of the family in treatment	yes	importance of a supportive post-discharge environment	yes	yes
2. Specific training in in social norms and skills	yes		yes	training basic life skills
3. Matching client to program approach or worker interaction style	yes		yes	
4. Obtaining and maintaining a job	yes		yes	
5. The degree to which a youth feels responsible for himself	yes			

It should be noted that while family involvement appears very important for a successful outcome, several studies with older adolescents report success without parental involvement. The importance of this factor may be influenced by the age of the child. Furthermore, family involvement per se is likely not sufficient, even though it probably increases the likelihood of a supportive post-discharge environment. As indicated on pages 79-81, research suggests that family therapy is most effective when it:

- assists family members to learn to give clear messages and to negotiate with each other, and/or

- trains parents to change their child's behavior by appropriate and consistent contingencies.

Timing may also be important. It appears to be beneficial to initiate family therapy immediately after referral in order to capitalize on the motivation present at that point.

The value of giving children and adolescents specific instruction in social norms and appropriate behaviors is strongly suggested by several reports. Modelling and role playing are methods that appear helpful in doing this.

Several articles with delinquents indicate that matching client with program type or worker style is beneficial. Good descriptions of this method appear in the reports of Palmer (1974) and Barkwell (1980). The literature in regard to emotionally disturbed youngsters does not appear to address this issue explicitly. However, Rubenstein et al (1978) note that no one approach is suitable for all children. This observation supports the notion of individualized treatment.

For older adolescents, obtaining and maintaining a job appears correlated with improved behavior. Walter and Mills, in the article prepared for the Ross and Gendreau reader, note that youths in their program stated that they appreciated the sense of autonomy associated with having a job. It appears that having a job contributes to the youth's sense of self-worth.

Shyne's (1973) observation that the majority of outcome studies incorporating experimental designs appear to have been done with programs for juvenile delinquents was borne out by the present literature review. In addition, none of the reports pertaining to the treatment of emotionally disturbed youngsters dealt with those who were psychotic or severely neurotic, except Bauman (1976). In other words, all the findings discussed above pertain to children who could be categorized as conduct or behavior-disordered. This raises the question of whether or not factors found important in the treatment of delinquents would also be important in the treatment of many of the children on the caseload of a children's mental health centre or a children's aid society. The answer is probably yes. Shamsie (1981) notes that acting out behavior is "possibly the largest single basis for clinical referral of children to mental health centres" (p. 358) and that 72.9% of referrals to Thistletown Regional Centre between 1977 and 1979 had disruptive behavior as one of the major presenting problems.

Summary of the Findings

The literature review indicates that some treatment approaches do work. However, there is no universal panacea for all disturbed or disturbing children. On the basis of the review, the following factors appear associated with success:

- involvement of the family in treatment (although some studies with older adolescent delinquents report success without family contact)
- specific training of the youngster in social norms and skills
- matching of client to program type or worker interaction style
- obtaining and maintaining a job (for older adolescents).

Other important findings are that:

- intervention does not have to be expensive to be effective
- a successful outcome can result from the use of non-professionals or parents acting as therapists for their children
- short-term outpatient therapy can have a significant impact.

The majority of outcome studies meeting the criteria for inclusion in this review were done with programs for juvenile delinquents, that is to say, youngsters categorized as conduct-disordered. While the findings relate to conduct disorders, the factors associated with success are likely also to have broad application throughout children's services.

7. CONCLUSIONS

This paper has attempted to track trends from 1950 to 1980 in both residential and non-residential service in four children's services sectors: child welfare, corrections, mental retardation and children's mental health. As noted in the text, the statistics in the paper should be viewed as rough indicators of overall trends, given the limitations of the data. Nonetheless, the available data appear to provide adequate support for the following generalizations about trends in children's services in the period from 1950 to 1980:

- A belief that specialized residential services were in the best interests of children led to an increase in the use of these services and an expansion of residential facilities that peaked around 1970.
- A shift in focus to meeting children's needs in the community in more "normalized" settings resulted in the development of smaller residential facilities.
- An increasing emphasis on working with children in their own homes led to an expansion of non-residential services, increasingly involving work with both children and adults.

Tables 41, 42 and 43 summarize the effects of these trends on rates of both residential and non-residential service in the various children's services sectors. Admittedly, some rates are based on numbers receiving service as of a given date, others on total numbers served during the year. Also, comparative figures for 1950 and 1980 are not available for either the large children's mental health services category or observation and detention homes. The crude total of residential rates of service in Table 41 indicates that the overall rate of residential service was significantly lower in 1980 than in 1950. The crude total of non-residential rates in Table 42, on the other hand, indicates that the rate of non-residential service more than doubled between those years, although data are not available for children's aid society community services, correctional diversion programs and non-residential services provided by children's institutions. As a result, the overall rate of service -residential and non-residential service combined (Table 43) - was about 30% higher in 1980 than in 1950 if foster care is excluded from the residential category, and 13.3% higher if foster care is included.

Table 41

Rates of Residential Service per 100,000 Children under 18

Residential Services	1950	1970	1980
Child Welfare			
- In the care of children's aid societies at end of year	1,347.7	675.8	539.8
- Served by children's institutions during year	389.1	109.4	86.9
- Served by children's boarding homes during year	-	14.4	113.9
Juvenile Corrections			
- On training school rolls on April 1	59.2	53.3	25.7
- On correctional group home rolls on April 1	-	-	5.0
- In residence in observation and detention homes on April 1	N.A.	N.A.	6.6(1)
Mental Retardation Services			
- In Schedule I and II facilities	95.4	111.1(2)	73.0(2)
- In homes for special care	-	10.1(2)	8.9(2)
- In community residential programs	-	-	9.7(3)
Children's Mental Health Services			
- Residential treatment in general hospitals and children's mental health centres	N.A.	65.8	567.9
	1,891.4	1,039.9	1,437.4

1. Based on 1975 data.
2. Residents aged 0-19.
3. Calculated on basis of estimated population aged 0-19.

Source: Tables 1, 2, 13, 23,24,31, and 32.

Table 42

Rates of Non-Residential Service per 100,000 Children under 18

Non-Residential Services	1950	1970	1980
Child Welfare			
- Children's aid society protection and prevention cases carried forward	666.8	439.5	882.0
- Unmarried mothers cases carried forward	334.8(1)	176.1	85.2
- Society-placed children on adoption probation	180.7(2)	204.7	68.4
Juvenile Corrections			
- Admitted to probation and aftercare during year	108.2	162.1(3)	215.9
Mental Retardation Services			
- In schools for the trainable mentally retarded	18.3	194.4(4)	300.8(5)
- In developmental day nurseries	-	-	53.3(5)
- In integrated day nurseries	-	-	7.3(5)
- In other community support programs	-	-	175.8
Children's Mental Health Services			
- Outpatient service by children's mental health centres	-	-	1,109.9
	1,308.8	1,176.8	2,898.6

1. Does not include the Toronto societies.
2. Based on data for 1960.
3. Estimate based on average of 1950 and 1980 total.
4. Estimate based on average of 1965 and 1975 total.
5. Based on data for 1981.

Source: Tables 1, 6, 7, 8, 23, 26, 28, and 32.

Table 43

Overall Rates of Service per 100,000 Children Under 18

	1950	1970	1980	1950-1980
Residential service excluding foster care	1,891.4	1,039.9	1,437.4	-24.0
Non-residential service	1,308.8	1,176.8	2,898.6	121.5
Total	3,200.2	2,216.7	4,336.0	35.5
Residential service including foster care	2,555.7	1,465.0	1,732.1	-32.2
Non-residential service	1,308.8	1,176.8	2,898.6	121.5
Total	3,864.5	2,641.8	4,630.7	19.8

Source: Tables 41 and 42; Table 3 for foster care data.

The question arises as to whether the combined rates of service in Table 43 reflect a higher overall level of service in reality. In considering these crudely totalled rates of service, it must be kept in mind that an unknown amount of double counting of service recipients is inevitable, given the possibility that an individual child will be served by more than one service stream in the course of a year. In the absence of other information, it makes sense to assume that the rate of duplication has been fairly constant despite shifts in patterns of service. On the other hand, a study of the average duration of incidents of service not attempted for this paper -might well find that in most or all sectors of children's services, as in training schools and residential children's mental health services, the length of service has declined. Despite these qualifications, it seems reasonable to conclude that the overall level of service has increased as a result of the growth of non-residential services.

The trend to non-residential service is in line with the Ministry's policy, expressed in a number of statements in recent years, of supporting provision of services to children within their families, wherever possible. It should be emphasized that this is not always either desirable or feasible. Decisions for Care (draft Ministry policy paper, October 1983) presents a framework for decision making by child protection workers, and states that primacy must be given to the safety of the child:

- Children in emergency situations often face an imminent threat of serious injury, and unless they can be protected in some other way, they should be placed in care immediately until the home is considered safe.

- When children are living in chronically dangerous situations the CAS should not wait until the child is harmed before taking action. If the parent engages in harmful conduct toward the child, that will result in serious injury to the child if it continues for a sufficient length of time, then the CAS should intervene. Although an element of prediction is involved in these situations the CAS should not wait until the child is harmed before taking action (p.34).

Lambert, who studied training school children, similarly warns against making assumptions about the feasibility of working with all "families" or "parents".

> When we reviewed the files of training school wards, we found that some had had so many disruptions in living situations, or in the adults in parenting roles, that it was necessary to be very explicit in the definition of "mother" or "family" in terms of the number of years or months specific situations existed. For example, by the time of the delinquent act first being committed, some children had been moved among a number of guardians, such as a step-parent, grandparent, older sibling, friend of family, mother of mother's boyfriend, etc. In cases such as these, a family therapy approach is not realistic. It was with this knowledge, and for this group of youngsters, that the Lambert-Birkenmayer report recommended an increase in group homes as an alternative to training school (44).

The statistics in the paper do not provide support for an analysis of the quality of service or of its rising cost. With respect to these two issues, the literature review in chapter 6 cites some encouraging findings about the effectiveness of treatment approaches. Specifically:

- Factors associated with success include involvement of the family in treatment, training of the child in social norms and skills, and employment (for older youths) (45).
- Intervention does not need to be expensive to be effective. Use of non-professionals or parents as therapists can result in a successful outcome. Short-term outpatient therapy can have a significant impact.

Similarly, recent investigations of the effectiveness of social work methods, using improved research designs, and appropriate controls, have called into question earlier negative findings. The recent studies indicate that direct social work intervention with child and family clients can and does result in positive outcomes (Reid & Hanrahan, 1982).

This paper was developed with the intention of bringing together both data on trends in children's services and research findings that would contribute to an informed understanding of such policy and service planning issues. It is the Ministry's expectation that the material in the paper, gathered from a wide range of sources and brought together in this way for the first time, will be a useful tool for policy makers and service planners.

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44. Dr. Leah Lambert, personal communication.
45. Comparable findings were reported by Lambert & Madden (1976). They found that employment success and family ties were the most important factors associated with reduced recidivism in a group of female offenders who had served terms at the Vanier Centre for Women. (Many in the sample were aged 16-19; Dr. Leah Lambert, personal communication.)

The findings on factors associated with successful intervention, whether residential or non-residential, should be considered both in program reviews and in case planning for the individual child or family. For example, the finding concerning the importance of post-discharge follow-up in maintaining gains made in residential care confirms what has been regarded as good practice for some time, and demonstrates the need to keep this factor in mind in the selection and use of residential services.

The research findings in this paper do not deal with the range of non-residential services that are now commonly referred to as family support services. The Ministry has recently published a paper titled The Nature and Effectiveness of Family Support Measures in Child Welfare that should be seen as a companion paper to this one. It represents a "state of the art" review of family support services, and fills in the gaps noted in this paper. While the focus of the family support paper is on child welfare, the findings it presents transcend the boundaries of child welfare services. Taken together, these papers update our knowledge of and provide program development direction for a range of children's services.

APPENDIX A

DATA ON CHILDREN IN MENTAL RETARDATION FACILITIES

Establishing meaningful statistics regarding the number of mentally retarded children in residential facilities is a challenge. During most of the period from 1950 to 1980, a child in the care of a provincial institution with a primary diagnosis of mental retardation usually, but not necessarily, lived in an institution designated for mentally retarded persons. A small proportion lived in institutions for the mentally ill. In 1950, the Hospitals Division of the Department of Health operated 16 Ontario Hospitals with a total of 1,508 children (aged 19 or less) in residence. Of these children, 1,242 lived in the Ontario Hospital School at Orillia. The other 15 facilities served from five to 64 children, predominantly in the 15 to 19-year-old age group. Only three of the facilities, those at Aurora, Cobourg and Orillia, were designated for mentally retarded persons (Schedule I facilities under the Mental Hospitals Act). The others served primarily adults classified as mentally ill.

Although new facilities were established over the years, one-third of Ontario's mental retardation facilities as of 1976 had been classified as psychiatric in 1950. In 1970, the Mental Retardation Branch of the Department of Health administered nine mental retardation facilities. By 1975, when the Branch was transferred to the Ministry of Community and Social Services, the number of mental retardation facilities had grown to 14. Three of the additions were originally psychiatric institutions, and two were newly established government-operated facilities. By 1976, the number of mental retardation facilities had reached 19. All five additions had also originally been designated as psychiatric institutions for the mentally ill. With the closure of a facility in North Bay and the transfer of a Kingston facility to a community board as a Schedule II facility(46), the number of mental retardation facilities was reduced to 17 by the end of 1977.

To avoid statistical distortions, the data on children in mental retardation facilities for each year beginning with 1950 include those in psychiatric facilities that were later designated as mental retardation facilities. Two alternative statistics are available, children "on the books" and children "in residence". The number of children on the books is larger than the number of children in residence. Most of the differences between these two numbers is due to children being on leave of absence on March 31 or December 31 of the given year. A few "children on books", usually 15 to 19-year-olds, actually lived in approved homes, which are foster care-type family homes providing care to some residents of facilities. The numbers of children in approved homes were so small that they do not affect the overall rates to be discussed.

Table 44 shows that in 1950, 86% of all children on the books of the three mental retardation facilities and the 13 psychiatric facilities had a primary diagnosis of mental retardation. On the other hand, 88% of all children on the books of the institutions resided in mental retardation facilities. Evidently, mental retardation facilities had in their care some children whose primary diagnosis was not mental retardation. Moreover, some children with a primary diagnosis of mental retardation, usually in the 15 to 19-year-old age group, lived in each psychiatric facility. This situation was consistent throughout the period under consideration. Other data for every year between 1950 and 1972 not shown in Table 44 indicate that children with a primary diagnosis of mental retardation constituted an average of 84% of all children in care in Ontario's mental retardation and psychiatric facilities.

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46. Schedule II facilities were not designated as such prior to 1974. However, they can be traced back to 1962 when they were classified as private mental institutions that reported to the Mental Health Branch of the Department of Health. Subsequently, they were classified as private mental institutions for profoundly mentally and physically handicapped children.

Table 44

Children(1) On Books of Government-Operated Mental Retardation (Schedule I) and Psychiatric Institutions

Year	All Children	Mentally Retarded Children	Per Cent Mentally Retarded Children	Per Cent Children in M.R. Facilities Only
1950	1,508	1,290	85.5	88
1955	2,776	2,303	83.0	N.A.
1960	4,064	3,266	80.4	N.A.
1965	5,117	4,160	81.3	N.A.
1970	4,018	3,462	86.2	N.A.
1975	N.A.	N.A.	N.A.	N.A.
1980	N.A.	N.A.	N.A.	N.A.

1. Children aged 0-19 years.

Source: Annual reports of: Hospital Division, Department of Health (1950 and 1955); Mental Health Branch, Department of Health (1960); Mental Health Division, Department of Health (1970).

During the period under discussion, the number of children in mental retardation facilities increased remarkably each year until 1965, then declined significantly but less dramatically until 1980, a trend that continued into 1982. This number increased almost twofold (197%) between 1950 and 1965, then decreased by half (53%) by 1980. Although Ontario's child population aged 19 or younger increased by 84% between 1950 and 1980, there were fewer children in Schedule I facilities in 1980 than in 1950, as shown in Table 45.

Table 45

Children (1) in Residence in Mental Retardation Facilities

Year	Schedule I Facilities	Schedule II Facilities	Both	% Change
1950	1,425	-	1,425	-
1955	2,161	-	2,161	-
1960	3,087	-	3,087	-
1965	4,012	223 (est.) (2)	4,235	+197.2
1970	2,890	342 (est.)	3,232	-
1975	1,799	531 (est.)	2,330	-
1980	1,283	721 (actual)	2,004	-52.7

1. Children aged 0-19 years.

2. Based on actual data for 1978 through 1981, children were estimated at 70% of residents.

Source: See Table 44; Schedule I and II 1975 and 1980 data are abstracted from various Ministry of Community and Social Services documents.

A more meaningful way to examine the data is to take population trends into account by calculating the institutionalization rate among mentally retarded children, i.e., how many children per 100,000 from birth through 19 years of age were residents in mental retardation facilities. Table 46 shows that the almost twofold increase in the number of children in mental retardation facilities between 1950 and 1965 was in part an artifact of demographic factors. The actual increase during this period in the institutionalization rate was 62%, while the rate decreased by 68% from 1965 to 1980. In fact, there were proportionately fewer children in mental retardation institutions in 1975 than in any period from 1950 to that time. Between 1965 and 1975, the rate of institutionalized children in mental retardation facilities fell from its all-time peak of 154 per 100,000 children to 80 per 100,000 children. By 1980, the rate was down further to 73 per 100,000 children.

Table 46

Children (1) in Residence in Mental Retardation Facilities: Rate per 100,000

	Children in Ontario	Children in Schedule I Facilities: Rate per 100,000	Children in Schedule I & II Facilities: Rate per 100,000	Per Cent Change
1950	1,493,100	95.4	95.4	-
1955	1,893,300	114.1	114.1	-
1960	2,361,900	130.7	130.7	-
1965	2,745,500	146.1	154.3	+ 61.7
1970	2,980,000	99.4	111.1	-
1975	2,903,600	62.0	80.2	-
1980	2,744,000	46.8	73.0	- 52.7

1. Children aged 0-19 years.

Source: Population statistics from Demography Division, Statistics Canada: Intercensal Estimates of the Population by Sex and Age, Canada and the Provinces. Other data are derived from Table 24.

Data available for 1981 suggest that the decline had stabilized. In 1981, there were 2,046 children aged 19 or under in Schedule I and II facilities, while the federal census reported the number of children in Ontario in this group as 2,685,530. The rate of institutionalization was therefore 76.1 per 100,000.

Another source of residential care for the mentally retarded that should be considered is the Homes for Special Care Program. Between 1970 and 1980 there were about 2,000 mentally retarded persons in these residential settings. In 1980 there were 2,170 mentally retarded and 7,400 mentally ill residents in homes for special care. Although precise data on the number of children in homes for special care for the years under discussion are not available, it is possible to estimate the number based on government reports indicating that there were 400 "children", probably 18 years and under, in these homes in 1973. By 1977, the number had declined to 230. It is also known that in July 1982 there were 243 children, aged 19 or under, in homes for special care. Table 47 presents estimates of the numbers of mentally retarded persons in homes for special care in the years 1970, 1975 and 1980.

Table 47

Mentally Retarded Persons in Homes for Special Care: Estimates

	Nursing Homes	Residential Homes	Total	Children 0-18	Children 0-19
1970	908	286	1,194	278	293
1975	1,827	653	2,390	361	381
1980	1,625	475	2,170(1)	148	243(1)

1. Actual figure for 1982. All other figures are estimates. See text.

Source: Policy Development Branch, Ministry of Community and Social Services

If mentally retarded children in homes for special care from 1970 to 1980 are added to the children in mental retardation facilities, the previous analysis of the rate of instiutionalization is affected as shown in Table 24 in chapter 4.

APPENDIX B

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